

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5729
CERTIFICATE OF DEATH

05724

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. L. General Hosp.</i>		d. STREET ADDRESS <i>16 Carver St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Henrietta Adams</i>		4. DATE OF DEATH Month Day Year <i>6 11 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-15-1886</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>P</i>		14. MOTHER'S MAIDEN NAME <i>Annie Hebron</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <i>Walter Adams - 25 Bunch St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO <i>Nephrosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hemip</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/6</i> , 19 <i>56</i> , to <i>6/11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>6/11</i> , 19 <i>56</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>37 Calvert St., Annapolis, Md</i>	
DATE SIGNED <i>6/12/56</i>			
PHYSICIAN'S NAME (Type) <i>DR. THEODORE H. JOHNSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-13-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II</i>		ADDRESS <i>Annapolis, Md</i>	
24a. REC'D BY REGISTRAR <i>6-14-56</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. J. Prunch</i>	

CERTIFICATE OF DEATH

8733

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

8733

BUREAU V. 2

JUN 14 1956

RECEIVED

THEODORE H. JOHNSON

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05725

5757 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millersville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Maggie</u> (First) <u>Arrington</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>6</u> (Day) <u>18</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 15, 1876</u>		9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Bayne</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Boblitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Family Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>204.2</u> IMMEDIATE CAUSE (A) <u>Acute Monocytic Leukemia</u>						<u>3+ weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Generalized arteriosclerosis</u>		<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/18</u> , 19 <u>56</u> , to <u>6/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/13</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shupley</u>				ADDRESS (Street, city, town, state) <u>M.D. 63 College Ave Annapolis Md 21403</u>		DATE SIGNED <u>6/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>6-21-56</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>		ADDRESS <u>Towson, Maryland</u>	

CERTIFICATE OF DEATH

NAME (Print or Write)

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

BY WHOM DEATH WAS CERTIFIED

SIGNATURE OF DEATH CERTIFIER

DATE

PLACE

BY WHOM DEATH WAS CERTIFIED

SIGNATURE OF DEATH CERTIFIER

DATE

PLACE

BY WHOM DEATH WAS CERTIFIED

SIGNATURE OF DEATH CERTIFIER

DATE

PLACE

BY WHOM DEATH WAS CERTIFIED

SIGNATURE OF DEATH CERTIFIER

DATE

PLACE

BY WHOM DEATH WAS CERTIFIED

BUREAU A. 2

JUN 21 1956

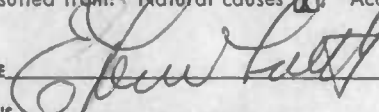
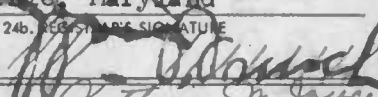
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726
Reg. Dist. No. 28

5758

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 3 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last VIRGIE A ASBURY				4. DATE OF DEATH Month Day Year JUNE 19, 19 56													
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1921		9. AGE (In years last birthday) 35 yrs. IF UNDER 1 YEAR: Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Yeager, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cooper						14. MOTHER'S MAIDEN NAME Maggie (Unknown)											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Arthur Asbury- husband- same as # 2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes													
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6-19-56 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Elmer G. Linhardt				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED June 19, 1956									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery				22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME						ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE 6/20/1956		24b. REGISTRAR'S SIGNATURE 							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Office of the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 13
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 21 1956

RECEIVED

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Age of Deceased		Sex of Deceased	
Race of Deceased		Color of Deceased	
Marital Status		Occupation	
Usual Residence		Place of Birth	
Cause of Death		Manner of Death	
Immediate Cause		Underlying Cause	
Contributing Cause		Morbidity	
Mortality		Disposition of Body	
Signature of Examiner		Signature of Coroner	
Date of Examination		Date of Certification	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05727

5759

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7214 MARLEY NECK RD</u>				d. STREET ADDRESS <u>7214 MARLEY NECK RD</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPHINE</u> <u>BOZER</u>				4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>19</u> <u>1956</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH</u> <u>1896</u>			
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>					
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>					
17. INFORMANT <u>FRANK BOZER</u>				Address <u>7214 MARLEY NECK RD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cardiac decompensation</u> DUE TO (c) <u>generalized arteriosclerosis</u> <u>not known</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized hypertrophic arthritis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>January 4, 1955</u> , to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>					
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				DATE SIGNED <u>June 19, 1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE HWY A.D.C., MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Ronce</u>				ADDRESS <u>4001 Ritchie Hwy</u>		24a. REC'D BY REGISTRAR <u>DATE 6-22-56</u>			
24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>									

05712

BUREAU V. 3

JUN 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Page 1 should be cut the certificate and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05728

Reg. Dist. No.

5760

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montivideo Rd.</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Buffen</u> First Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>24th</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/19/05</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Buffen</u>				14. MOTHER'S MAIDEN NAME <u>Amelia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2P7-09-1322</u>		17. INFORMANT <u>Mrs. Amelia Buffen (Mother)</u> <u>Baltimore, md.</u> Address: <u>3807 Coolidge Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Wm. V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard, 4107 Wilkens Ave.</u>				24a. REC'D BY REGISTRAR <u>JUN 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Haskins</u>	

RECEIVED

JUN 28 1956

BUREAU V. 3

STATE DEPARTMENT OF HEALTH - BATHING

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15M 9/55

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. D.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u>		b. COUNTY <u>A. D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Calvert</u>		First <u>Calvert</u> Middle <u>W.</u> Last <u>Burley</u>		4. DATE OF DEATH <u>June 98</u>		Month <u>98</u> Day <u>98</u> Year <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 12 1907</u>	
				9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labork P. Bel Bond Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bristol Ind</u>		11. BIRTHPLACE (State or foreign country) <u>D.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Burley</u>		14. MOTHER'S MAIDEN NAME <u>Louise Baden</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(if yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>217-16-1946</u>		17. INFORMANT <u>Josephine Burley</u>		Address <u>Bristol Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>023X</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Luetic CV Disease</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 24</u> , 19 <u>54</u> , to <u>28 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 June</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Jasser</u>				M.D. <u>Upper Marlboro Ind</u>		DATE SIGNED <u>6-28-56</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>Bristol Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Jasser</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>July 2, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Ida Belle Smith</u>	

1956 3 701

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5730 CERTIFICATE OF DEATH

05730

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>93 East Street</u>		d. STREET ADDRESS <u>93 East Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Ray</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Ray</u>		14. MOTHER'S MAIDEN NAME <u>Maragret Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>8</u>	
17. INFORMANT <u>Gladie Simms-93 East St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardiovascular Dis</u> DUE TO (c) <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 wk.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> to <u>JUNE</u> , 19 <u>56</u> that I last saw the deceased alive on <u>JUNE 10</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		DATE SIGNED <u>6-12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Dr Wm J. French</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>6-14-56</u>			

CERTIFICATE OF DEATH

2120

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11-581

BUREAU V. 3

JUN 14 1956

RECEIVED

1
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05731

5762 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Kentucky</u>		COUNTY <u>Jefferson</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort G. G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>2 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Louisville</u>		<u>55X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>734 S. Shelton Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PAUL</u>		(Middle) <u>DAVID</u>		(Last) <u>CATHEY</u>		(Month) <u>June</u> (Day) <u>30</u> (Year) <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>29 June 1956</u>	9. AGE last birthday yrs. <u>9</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Cathey</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Deane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Apt T-1235-C Fort Meade, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Anoxia</u>				<u>Anoxia</u>		<u>9 Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atelectasis</u>				<u>Atelectasis</u>		<u>9 Hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C) <u>Immaturity</u>				<u>Immaturity</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 June</u> , 19 <u>56</u> , to <u>30 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>30 June</u> , 19 <u>56</u> , and that death occurred at <u>0830</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Richard M. McQuane</u>		RICHARD M. MCQUANE IST LT, MSC M.D.		ADDRESS (Street, city, town, state) <u>U. S. A. Ft. Meade, Md.</u>		DATE SIGNED <u>30 June 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. J. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cock, Inc., Balto., Md</u>		ADDRESS	
DATE <u>30 June 56</u>		W. J. SAYLOR, IST LT, MSC					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form No. 10-57

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF VENDOR

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

BUREAU V. 1

JUL 5 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5763

CERTIFICATE OF DEATH

05732

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lothian			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moreland Nursing Home				d. STREET ADDRESS Moreland Nursing Home			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EMMA Middle M Last CHESTNUT				4. DATE OF DEATH Month JUNE Day 20 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30 1869	
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asaph Sherwood				14. MOTHER'S MAIDEN NAME Delphine Bussee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. nOne		17. INFORMANT Personal records of Deceased			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 2, 1954 to June 20, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emily H. Wilson M.D.				ADDRESS (Street, city or town, state) Lothian, Md DATE SIGNED 6-21-56			
PHYSICIAN'S NAME (Type) Emily Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE 6/27/56		24b. REGISTRAR'S SIGNATURE Elvis H. Williams	

CERTIFICATE OF DEATH

1956

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Office of registration	
13. Name of informant		14. Relationship to deceased		15. Signature of informant	
16. Name of funeral home		17. Address of funeral home		18. Signature of funeral home	
19. Name of cemetery		20. Address of cemetery		21. Signature of cemetery	
22. Name of undertaker		23. Address of undertaker		24. Signature of undertaker	
25. Name of physician		26. Address of physician		27. Signature of physician	
28. Name of nurse		29. Address of nurse		30. Signature of nurse	
31. Name of pharmacist		32. Address of pharmacist		33. Signature of pharmacist	
34. Name of dentist		35. Address of dentist		36. Signature of dentist	
37. Name of optician		38. Address of optician		39. Signature of optician	
40. Name of veterinarian		41. Address of veterinarian		42. Signature of veterinarian	
43. Name of other health professional		44. Address of other health professional		45. Signature of other health professional	
46. Name of other health professional		47. Address of other health professional		48. Signature of other health professional	
49. Name of other health professional		50. Address of other health professional		51. Signature of other health professional	
52. Name of other health professional		53. Address of other health professional		54. Signature of other health professional	
55. Name of other health professional		56. Address of other health professional		57. Signature of other health professional	
58. Name of other health professional		59. Address of other health professional		60. Signature of other health professional	
61. Name of other health professional		62. Address of other health professional		63. Signature of other health professional	
64. Name of other health professional		65. Address of other health professional		66. Signature of other health professional	
67. Name of other health professional		68. Address of other health professional		69. Signature of other health professional	
70. Name of other health professional		71. Address of other health professional		72. Signature of other health professional	
73. Name of other health professional		74. Address of other health professional		75. Signature of other health professional	
76. Name of other health professional		77. Address of other health professional		78. Signature of other health professional	
79. Name of other health professional		80. Address of other health professional		81. Signature of other health professional	
82. Name of other health professional		83. Address of other health professional		84. Signature of other health professional	
85. Name of other health professional		86. Address of other health professional		87. Signature of other health professional	
88. Name of other health professional		89. Address of other health professional		90. Signature of other health professional	
91. Name of other health professional		92. Address of other health professional		93. Signature of other health professional	
94. Name of other health professional		95. Address of other health professional		96. Signature of other health professional	
97. Name of other health professional		98. Address of other health professional		99. Signature of other health professional	
100. Name of other health professional		101. Address of other health professional		102. Signature of other health professional	

RECEIVED
JUN 27 1956
BUREAU A. 3

Page 1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5731
CERTIFICATE OF DEATH

05733

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Southgate Ave.</u>		d. STREET ADDRESS <u>15 Southgate Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>ROSALYN SYLVESTER CHEW</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Sylvester</u>		14. MOTHER'S MAIDEN NAME <u>Marinda Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Capt. John L. Chew U.S.N. #2</u>	
17. INFORMANT <u>Capt. John L. Chew U.S.N. #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Azotemia</u> DUE TO <u>Hypertensive Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalised</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2, 1956</u> to <u>June 4, 1956</u> , that I last saw the deceased alive on <u>June 2, 1956</u> and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>6/5/56</u>	
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> <u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>John M. Taylor and Sons</u> 24b. REGISTRAR'S SIGNATURE <u>John M. Taylor and Sons</u> DATE <u>JUNE 5, 1956</u>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

956 9 NDR

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05734

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Q. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JOSEPH</i> Middle <i>CLINTON</i> Last <i>COLLIFFLOWER</i>		4. DATE OF DEATH Month <i>June</i> Day <i>16</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10 1954</i>
9. AGE (In years last birthday) <i>2</i> yrs.		IF UNDER 1 YEAR Months <i>2</i> Days <i>6</i> Hours <i>16</i> Min. <i>4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>NORTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE C COLLIFFLOWER</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET L. COCKRELL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>GEORGE C. COLLIFFLOWER</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO <i>Drowning</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Sudden</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lee of Press</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Beach</i>	
20c. TIME OF INJURY Month <i>6</i> Day <i>16</i> Year <i>1956</i> Hour <i>PM</i> Min. <i>12</i> P.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Beach</i>		20f. (City or town) <i>A. R. MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Howard</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Howard</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/18/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ST. MARY'S CEM</i>		22d. LOCATION (City, town, or county) <i>ANNAPOLIS MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>DATE 6-18-1956</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>J. D. Darnell</i>	

NAME: *George C. Coffey*
AGE: *42*
SEX: *Male*
DATE OF DEATH: *May 10 1956*
PLACE OF DEATH: *North Carolina*
CAUSE OF DEATH: *George C. Coffey*

BUREAU A. 1

1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05735

Reg. Dist. No. 28

5765

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>3m. 21 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elyaton (Old Joppa Rd.)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernadette</u> Middle <u>Day</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/56</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u>	
11. IF UNDER 24 HRS. Hours <u>21</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Day</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Evangeline Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hilda E. Day (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration of vomitus.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>921.0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/15/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried June 17/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Annal A. Johnson</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Katharine M. Joyce</u>	

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MASSACHUSETTS DEPARTMENT OF HEALTH—DIVISION 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 18 1956

RECEIVED

5732

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Md.				d. STREET ADDRESS Gambrills, Md.			
3. NAME OF DECEASED (Type or print) First Middle Last Clifford Vernon DEFOREST				4. DATE OF DEATH Month Day Year 6 24 1956			
5. SEX M	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-87	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 4 3	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b. KIND OF BUSINESS OR INDUSTRY RET		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elem E. DEFOREST				14. MOTHER'S MAIDEN NAME HEAGIE, Gertrude			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address U.S. Naval Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure Heart Congestive 434.1 4/20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subacute Bacterial Endocarditis 430.0 (c) Arteriosclerotic Heart Disease 420.0 10 Years							INTERVAL BETWEEN ONSET AND DEATH 02 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-19-56, 19 to 6-24-56, 19 that I last saw the deceased alive on 6-24-56, 19 56, and that death occurred at 0735 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S.S. WRIGHT, LT MC USNR M.D. USNH, Annapolis, Md. 6-24-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) S.S. WRIGHT, LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-27-56		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson 60				ADDRESS 1300-N 9th NW Washington, D.C.		24a. REC'D BY REGISTRAR DATE JUN 26 1956	
				24b. REGISTRAR'S SIGNATURE J. J. French			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5766 CERTIFICATE OF DEATH

05737

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 11 mos 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Baltimore City	
3. NAME OF DECEASED (Type or print) First Lillian Middle Delaney Last Delaney		4. DATE OF DEATH Month 6 Day 23 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 13 85
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 9 Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jack Smith		14. MOTHER'S MAIDEN NAME Mamandor Langley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers, Malnutrition, Pneumonia, Pyelitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 28 55 , 19 55 , to 6 23 , 19 56 , that I last saw the deceased alive on 6 22 , 19 56 , and that death occurred at 05 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict		DATE SIGNED 6 23 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Amelia Va		22d. LOCATION (City, town, or county) (State) Amelia Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Miss Kate R. Williams		ADDRESS Schweizer St.	
24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

Reg. Dist. No.

10

5767

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryo</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Surfway Point</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>U. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>2073 Forest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Aubrey</u> <u>Donnell</u>				4. DATE OF DEATH Month Day Year <u>6</u> <u>27</u> <u>1956</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-22-1938</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Boy</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James J. Donnelly</u>						14. MOTHER'S MAIDEN NAME <u>Lucille Donnell</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>_____</u>				17. INFORMANT Address <u>James J. Donnelly - 2073 Forest Drive</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>_____</u> DUE TO (a), stating the underlying cause lost.												INTERVAL BETWEEN ONSET AND DEATH <u> sudden </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>while swimming</u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6:27</u> p. m. <u>56</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Surfway Point</u>				20f. (City or town) <u>Annapolis</u> (County) <u>U. A.</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>E. Linhardt</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>6/29/56</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-1-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers Best</u>				22d. LOCATION (City, town, or county) <u>13 est State</u> (State) <u>MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>						ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Edward Collins</u>	
DATE <u>6/29/56</u>						DATE									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*
2. SEX: *Male*
3. AGE: *45*
4. OCCUPATION: *Teacher*
5. PLACE OF BIRTH: *John Doe, Baltimore, Md.*
6. DATE OF BIRTH: *11/18/1910*
7. DATE OF DEATH: *11/18/1956*
8. TIME OF DEATH: *10:00 AM*
9. PLACE OF DEATH: *John Doe, Baltimore, Md.*
10. CAUSE OF DEATH: *Myocardial Infarction*
11. MANNER OF DEATH: *Natural*
12. SIGNATURE OF EXAMINER: *John Doe*
13. SIGNATURE OF WITNESS: *John Doe*
14. SIGNATURE OF CORONER: *John Doe*
15. SIGNATURE OF JURY: *John Doe*
16. SIGNATURE OF JUDGE: *John Doe*
17. SIGNATURE OF CLERK: *John Doe*
18. SIGNATURE OF ATTORNEY: *John Doe*
19. SIGNATURE OF MINISTER: *John Doe*
20. SIGNATURE OF CHURCH: *John Doe*
21. SIGNATURE OF FUNERAL HOME: *John Doe*
22. SIGNATURE OF BURIAL PLACE: *John Doe*
23. SIGNATURE OF CREMATOR: *John Doe*
24. SIGNATURE OF OTHER: *John Doe*

BUREAU V. S.

JUN 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5768

CERTIFICATE OF DEATH

05739

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne-Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magothy Beach Rd + Riverside</u>				d. STREET ADDRESS <u>Magothy Beach Rd + Riverside</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence S Emmons Sr</u>				4. DATE OF DEATH Month Day Year <u>6 27 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/28/1882</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Blower</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Swindell Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mr Nelson Emmons</u>				Address <u>408 E. Clement St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Arteriosclerotic Cardio-Vascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u> <u>4 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>6/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>56</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Riviera Beach, Md.</u>			
NAME (Type) <u>J. BRADY SMITH</u>				DATE SIGNED <u>6/27/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan + Son</u>				ADDRESS <u>24 Hollins St.</u>			
24a. REC'D BY REGISTRAR <u>L. J. Selby</u>				24b. REGISTRAR'S SIGNATURE <u>L. J. Selby</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 28 1951

REGENT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause etc. should be stated in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5769 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05740 71
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn River</i>		c. LENGTH OF STAY IN 1b <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Donald</i> Middle <i>E.</i> Last <i>FISHER</i>		4. DATE OF DEATH Month <i>6</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29th 1928</i>
9. AGE (In years last birthday) <i>28</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>24</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver of Small Tug Owens Boat Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Penn</i>	
11. BIRTHPLACE (State or foreign country) <i>Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Ernest E. Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy J. Witters</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes.</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Myrtle L. Fisher</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Water</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Thrown out of boat while making turn</i> 20c. TIME OF INJURY Month <i>6</i> Day <i>24</i> Year <i>1956</i> Hour <i>AM</i> a. m. <i>6:45</i> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Severn River</i> 20f. (City or town) (County) (State) <i>PACO MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>ELMER LINHARDT</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>ELMER LINHARDT</i>		DATE SIGNED <i>6/24/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6-26-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baptist Church</i>		22d. LOCATION (City, town, or county) (State) <i>Cassville PA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook/Inc.</i>		ADDRESS <i>1217 St Paul St</i>	
24a. REC'D BY REGISTRAR <i>June 26 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Chris Thelapp</i>	

NAME: *James P. [illegible]*
AGE: *20*
SEX: *Male*
DATE OF BIRTH: *Jan 28 1928*
PLACE OF BIRTH: *W. A.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Myocardial Infarction*
MANNER OF DEATH: *Natural*
SIGNATURE: *[illegible]*
DATE: *June 26 1956*

RECEIVED
JUN 26 1956
BUREAU V. R.
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5733
CERTIFICATE OF DEATH

05741

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>			d. STREET ADDRESS <u>215 Chester Ave</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Forrester</u> Middle Last			4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md</u>
13. FATHER'S NAME <u>Harry Bowie</u>			14. MOTHER'S MAIDEN NAME <u>Tossie Ennis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>110</u>		
17. INFORMANT <u>Isabel Forrester</u>			Address <u>72 East St Annapolis</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertension</u> DUE TO (c) <u>Cardiovascular disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>56</u> to <u>June 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>56</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robt. Richardson</u>			ADDRESS (Street, city or town, state) <u>110 - Clay St Annapolis, Md</u>		
PHYSICIAN'S NAME (Type) <u>William Reese II</u>			DATE <u>6-21-56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>			24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>		
ADDRESS <u>Annapolis, Md</u>			24b. REGISTRAR'S SIGNATURE		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Caution: The undersigned
 Doctor, before signing this
 Certificate, should be satisfied
 that the deceased was
 a resident of this State.

X

BUREAU V. 2

JUN 21 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9, Film G198 6-11-56 et Item 2, Film G198 6-12-56 et 05742
5770
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore A. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Patapsco Club, RFD # 6 Stella Maris Hospice			
3. NAME OF DECEASED (Type or print) First T. Middle JEROME Last GOLLERY				4. DATE OF DEATH Month June Day 5 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1890	
9. AGE (In years last birthday) 65 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director (rtd)				10b. KIND OF BUSINESS OR INDUSTRY Funeral			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Gollery				14. MOTHER'S MAIDEN NAME Catherine McDermott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-4901		17. INFORMANT Mrs. Garrett Hauser-4800 Lackawanna, College Pk., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/18 , 1952, to 6/5 , 1956, that I last saw the deceased alive on 5/10 , 1956, and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 14 E. Eager St DATE SIGNED ACTUAL SIGNATURE C. Edward Leach M.D. 14 E. Eager St PHYSICIAN'S NAME (Type) C. EDWARD LEACH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto				24a. REC'D BY REGISTRAR 17 May 1956		24b. REGISTRAR'S SIGNATURE L. J. De Alby	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05743

5771

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena TFD (Jacobsville)</u> c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena TFD (Jacobsville)</u> d. STREET ADDRESS <u>Rock Creek Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Mc</u> Last <u>Gray</u>			4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1956</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 31, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>McElville S. Dunlap</u>		
14. MOTHER'S MAIDEN NAME <u>Laura V. Jacobs</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT Address <u>Miss Florence Dunlap Pasadena, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444X Acute pulmonary edema</u> DUE TO (b) <u>auricular fibrillation</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 week</u> <u>unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <u>July 17, 1951</u> , to <u>June 1, 1956</u> , that I last saw the deceased alive on <u>June 1, 1956</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.		
21. ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D. <u>Pasadena, Md.</u> <u>June 1, 1956</u>			21. DATE SIGNED		
21. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D. Pasadena, Md.</u> <u>June 1, 1956</u>			22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
22b. DATE THEREOF <u>June 4, 1956</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		
22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>			23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		
24a. REC'D BY REGISTRAR <u>JUN 7 1956</u>			24b. REGISTRAR'S SIGNATURE <u>L. J. Dealla</u>		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 8

JUN 7 1956

RECEIVED

TO MAYOR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5734

CERTIFICATE OF DEATH

05744
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>173 Water Street</u>				d. STREET ADDRESS <u>173 Water Street</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1956</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-1915</u>		9. AGE (In years lost birthday) yrs. <u>40</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank Green Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cross</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>012-12-1024</u>				17. INFORMANT <u>Rosie Scott</u> Address <u>71 Water St. Annapolis, Md.</u>							
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>3 days</u> (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>13 hours</u>												INTERVAL BETWEEN ONSET AND DEATH <u>13 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Annapolis</u> (County) <u>MD</u> (State) <u>MD</u>							
21. I certify that I attended the deceased from <u>June 6, 1956</u> to <u>June 6, 1956</u> , that I last saw the deceased alive on <u>June 6, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>R.L. Richardson</u> M.D. <u>110-CLAY ST. ANNAPOLIS</u>				ADDRESS (Street, city or town, state)				DATE SIGNED <u>June 6, 1956</u>							
PHYSICIAN'S NAME (Type) <u>R.L. Richardson M.D.</u>				ADDRESS <u>110 Clay St., Annapolis, Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		22d. LOCATION (City, town or county) <u>Annapolis</u> (State) <u>MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>							
DATE <u>6-19-56</u>															

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

5734

DECEASED'S NAME (Print or Type) _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (Years) _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH (Print or Type) _____	
MANNER OF DEATH (Print or Type) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF DECEASED'S NEXT OF KIN _____		SIGNATURE OF REGISTRAR _____	
ADDRESS OF DECEASED _____		ADDRESS OF NEXT OF KIN _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

BUREAU V. 2

1956

RECEIVED

RECORDED

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore County							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 5yrs. 2mos.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson							
d. STREET ADDRESS 437 Pennsylvania Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Birdella		4. DATE OF DEATH Month 6 Day 26 Year 19 56							
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/05						
9. AGE (In years last birthday) 51 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.		
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland							
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.							
17. INFORMANT Hospital Records		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia with Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular Thrombosis and Coma DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from 6/19 , 19 56 , to 6/26 , 19 56 , that I last saw the deceased alive on 6/26 , 19 56 , and that death occurred at 3:35p.m. , from the causes and on the date stated above. ACTUAL SIGNATURE R. Weber M.D. DATE SIGNED 6/27/56 PHYSICIAN'S NAME (Type) Konstantin Weber									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/56							
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE R. Weber		24a. REC'D BY REGISTRAR DATE 7-3-56	24b. REGISTRAR'S SIGNATURE K. M. Jones						

JUL 10 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 4,9 FilmG199 6-22-56 et

5735

CERTIFICATE OF DEATH

05745

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>17 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Folesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LEVI</u> <u>Holland</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>10</u> , 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 20 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Shedyside</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Holland.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jane Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Hypertensive Bands - Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Uremia</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/13</u> , 19 <u>56</u> , to <u>6/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>56</u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Theodore H. Johnson M.D.</u>				ADDRESS (Street, city, town, state) <u>37 Calver Hall Annapolis, Md</u>		DATE SIGNED <u>6/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/13/56</u>		NAME OF CEMETERY OR CREMATORY <u>EBENERER</u>		LOCATION (City, town, or county) (State) <u>ITALESVILLE MD</u>	
24. REC'D BY REGISTRAR <u>6/13/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway</u>		ADDRESS	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

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BUREAU V. 2

11/14 1956

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RECEIVED

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5736

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen. Hosp. - (D.O.A.)				d. STREET ADDRESS -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIAN Middle B. Last HOLMES				4. DATE OF DEATH Month JUNE Day 23 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 25, 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 5 Days 3 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- U.S. Govt. Employee- Treasury Dept.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ----- Josetta				14. MOTHER'S MAIDEN NAME Elizabeth R. Josetta			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not Available		17. INFORMANT Frank Gutteridge, 2004-38th St. S.E., Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) 8 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 17, 1956 , to June 23, 1956 , that I last saw the deceased alive on June 17, 1956 , and that death occurred at 12 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE R. B. Basore M.D.				Hypermarcho Md 24-6-56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-27-56		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.				ADDRESS 1300 - N ST. N.W.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE John J. French							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAHARASHTRA STATE DEPARTMENT OF HEALTH-BANGALORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5737

CERTIFICATE OF DEATH

05747

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	d. STREET ADDRESS <u>500 Pleasant St.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 Pleasant St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William H. Holmes</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-1889</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Ilda Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes U.S. Army</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Marie Holmes</u>		Address <u>500 Pleasant St. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive Cardio</u> DUE TO (c) <u>Vascular disease grade III</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Feb 1956</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>56</u> , to <u>June 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>56</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110-Clay Street Annapolis Md.</u> DATE SIGNED <u>6/4/56</u>			
ACTUAL SIGNATURE <u>Richardson R.E.</u> M.D.		DATE SIGNED <u>6/4/56</u>	
PHYSICIAN'S NAME (Type) <u>Richardson R.E.</u>		II 0 Clay Street Annapolis Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William O'Keefe</u>		24a. REC'D BY REGISTRAR <u>Wm J. French</u>	
ADDRESS <u>Annapolis, Md.</u>		DATE <u>6/6/56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05748

5738

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, ANNAPOLIS	
c. LENGTH OF STAY IN 1b 9 years		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE ESTELLE IRELAND		4. DATE OF DEATH Month Day Year JUNE 16, 1956	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 8 1947
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St Margrette AA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY WATKINS IRELAND		14. MOTHER'S MAIDEN NAME MARY LOUISE GRIMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT mother - same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, overwhelming DUE TO P.W. right arm. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0			INTERVAL BETWEEN ONSET AND DEATH 24 hours
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell injuring right arm - P.W.
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. June 13 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Annapolis, A.A., Md.		(County) (State)	
21. I certify that I attended the deceased from June 16, 1956 , to June 16, 1956 , that I last saw the deceased alive on June 16, 1956 , and that death occurred at 6:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jesse L. Wilkins		DATE SIGNED 6/16/56	
PHYSICIAN'S NAME (Type) JESSE L. WILKINS		ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried June 21/56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. Calvaries		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold A. Johnson		24a. REC'D BY REGISTRAR Dr. Wm. J. French	
ADDRESS Annapolis		DATE 6-19-56	

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CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>Ad. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Ad. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 Highland Rd.</u>				d. STREET ADDRESS <u>202 Highland Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ellis</u> First <u>L. Dwayne</u> Middle <u>L.</u> Last				4. DATE OF DEATH <u>6</u> Month <u>9</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 16, 1916</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Brownsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>City of Baltimore</u>			
13. FATHER'S NAME <u>Ellis Dwayne</u>				14. MOTHER'S MAIDEN NAME <u>Laura Dwayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>101-123456789</u>			
17. INFORMANT <u>Dr. Dwayne L. Dwayne</u>				Address <u>202 Highland Rd. Marley Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRONCHOGENIC CANCER OF LUNG</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>30 JAN</u> , 19 <u>56</u> , to <u>9 JUNE</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 JUNE</u> , 19 <u>56</u> , and that death occurred at <u>6:42 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George E. Groleau</u> M.D. <u>MAIN ST. ELKRIDGE, MD</u> <u>10 JUNE 56</u> PHYSICIAN'S NAME (Type) <u>George E. Groleau</u> <u>Main St. Elkridge, Md.</u> <u>10 June 56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brownsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Brown</u> ADDRESS <u>10101 Hollins St.</u>				24a. REC'D BY REGISTRAR <u>John J. Dealba</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Dealba</u>	
DATE <u>6-11-56</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 12

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5774 CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE (Maryland)	COUNTY (Anne Arundel)
CITY (If outside corporate limits, write RURAL or give nearest town) X TOWN Rural - Laurel, Md.	LENGTH OF STAY (in this place) 28 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel, Md. (Rural)	47 x 3
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 District Training School Laurel, Md.		STREET ADDRESS (If rural give location) Laurel, Md.	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Earl	(Middle) Jackson	(Last) (alias Jones) (Illeg.)	(Date) June 4 1956
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Oct. 12, 1916
9. AGE last birthday: 39 yrs.		10. IF UNDER 1 YEAR: 7 Months 23 Days 7 Hours 1 Min.	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME: Irving Jackson		14. MOTHER'S MAIDEN NAME: Alice Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None	17. INFORMANT & ADDRESS: District Training School records	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Broncho pneumonia		2 days
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C) DUE TO		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebro spasm. Mental Defective	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 3, 1956, to June 4, 1956, that I last saw the deceased alive on June 3, 1956, and that death occurred at 5:45 A M, from the causes and on the date stated above.

SIGNATURE Francis M. Macintosh	ADDRESS District Training School Laurel, Md.	DATE SIGNED June 5, 1956
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF June 6, 1956	NAME OF CEMETERY OR CREMATORY District Training School
		LOCATION (City, town, or county) (State) Laurel, Md.

DATE REC'D BY LOCAL REGISTRAR June 5-56 Clara Klesch	REGISTRAR'S SIGNATURE John J. Moore Jr	24. FUNERAL DIRECTOR ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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5739

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md				d. STREET ADDRESS 10 College Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Mary Josephine JOHNS				4. DATE OF DEATH Month Day Year June 10 1956			
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-80	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Fred Johns - 10 College Ave. Annapolis		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 434.1 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertention DUE TO (c) Adrenal Cortical Adenoma				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 17 May, 19 56, to 10 June, 19 56, that I last saw the deceased alive on 10 June, 19 56, and that death occurred at 1122 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE P.O. Geib				M.D. USNH Annapolis, Md. 6-11-56			
PHYSICIAN'S NAME (Type) P.O. GEIB, CDR, MC, USN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-13-56		Brewer Hill		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
William Keese - Annapolis, Md						DATE 6-14-56	
				24b. REGISTRAR'S SIGNATURE			
				Dr. Wm. J. Lench			

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BUREAU A. S.

BOOKS & ARTS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. D. General Hosp.</u>				d. STREET ADDRESS <u>133 Eastern Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1885</u> 71 yrs.	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>56</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alexander Parker</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Bais</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>110</u>			
17. INFORMANT <u>Solomon Turner</u>				Address <u>133 Eastern Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus, Arteriosclerotic Heart Disease</u> <u>Heart Failure</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>June 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>110 - Day of Annapolis, Md</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>				ADDRESS <u>Annapolis, Md</u>			
24a. REC'D BY REGISTRAR <u>Dr. Wm. J. French</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>			

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25 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043

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JUN 21 1956

RECEIVED

5775

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 20yrs. 9mos. 17days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 18 N. Mount Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosie Middle Johnson Last Johnson		4. DATE OF DEATH Month 6 Day 24 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (Separated) <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not known
9. AGE (In years last birthday) 74? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Bertie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricle failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 48 , to 6/24 , 19 56 , that I last saw the deceased alive on 6/23 , 19 56 and that death occurred at 5:10a. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		DATE SIGNED 6/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6/29/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine M. Joyce		24a. REC'D BY REGISTRAR Katherine M. Joyce	
24b. REGISTRAR'S SIGNATURE Katherine M. Joyce		DATE	

Subscribed

E-J

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1956 AUG 27

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5776
CERTIFICATE OF DEATH

05752

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 14yrs. 4mos. 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS Not known e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Keene Last Keene		4. DATE OF DEATH Month 6 Day 21 Year 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1906? 9. AGE (In years last birthday) 50? yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John H. Keene		14. MOTHER'S MAIDEN NAME Augusta Jane Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kachexia DUE TO (c) Cancer of the intestines		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple metastasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 48 , to 6/21 , 19 56 , that I last saw the deceased alive on 6/20 , 19 56 , and that death occurred at 1:45a.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/21/56	
PHYSICIAN'S NAME (Type) Ludwig Benedict			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/56	22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital	22d. LOCATION (City, town, or county) (State) Crownsville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ralph H. Myers		24a. REC'D BY REGISTRAR 6-25-56	24b. REGISTRAR'S SIGNATURE K. M. Jace

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Place of Burial		Cause of Burial	
Occupation of Burial		Residence of Burial		Manner of Burial	
Signature of Burial Officer		Signature of Registrar		Signature of Coroner	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Place of Burial		Cause of Burial	
Occupation of Burial		Residence of Burial		Manner of Burial	
Signature of Burial Officer		Signature of Registrar		Signature of Coroner	

RECEIVED
JUN 28 1956
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5777

CERTIFICATE OF DEATH

05753

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Kay</u> Last <u>Key</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-26-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		11. IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Md. Tel. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Lothian, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wesley J. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-32-7453</u>			
17. INFORMANT <u>Cornelia N. Johnson</u>				Address <u>Lothian, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>?</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>untill</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>untill</u> , 19____, and that death occurred at <u>5-9</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Smith H. W. W. W.</u>				ADDRESS (Street, city or town, state) <u>Lothian, Md.</u>			
DATE SIGNED <u>6-27-56</u>							
PHYSICIAN'S NAME (Type) <u>acting in name</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese T. Annapolis, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>6/29/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Elmer H. Williams</u>				DATE			

BUREAU V. 3

JUN 29 1956

RECEIVED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5778

CERTIFICATE OF DEATH

05754

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR end, give nearest town) TOWN <u>Pt. Pleasant</u>		LENGTH OF STAY (in this place) <u>YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pt. Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pt. Pleasant, Md. (Shoreland Rd.)</u>				STREET ADDRESS (If rural give location) <u>Shoreland Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>John Jefferson Klein</u>				4. DATE OF DEATH (Month) <u>6</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>1/22/05</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Lewis Klein</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-10-5332</u>		17. INFORMANT & ADDRESS <u>Family Same</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>Carcinoma left lung & Metastasis.</u>						<u>3 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> N. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-20</u> , <u>1956</u> , <u>to</u> <u>6-22</u> , <u>1956</u> , <u>that I last saw the deceased alive on</u> <u>6-22</u> , <u>1956</u> , <u>and that death occurred at</u> <u>7:30 P.M.</u> , <u>from the causes and on the date stated above.</u> SIGNATURE <u>R. McDonald M.D.</u> ADDRESS (Street, city, town, state) <u>Eslen Burne M.D.</u> DATE SIGNED <u>6-22-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR <u>L. J. Sedlitz</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>MCCULLY FUNERAL HOME 130 E. Fort Ave.</u>		ADDRESS	

DATE JUN 26 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05755

5779

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferndale, Glen Burnie		LENGTH OF STAY (In this place) 3yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ferndale, Glen Burnie, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 Eugenia Ave				STREET ADDRESS (If rural give location) 21 Eugenia Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Claude		(Middle) Kintz		(Last) Kline		(Month) 6 - (Day) 13 (Year) 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 14, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meatcutter		10b. KIND OF BUSINESS OR INDUSTRY American Stores		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Israel Benjamin Kline				14. MOTHER'S MAIDEN NAME Ella Gaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes WW I		16. SOCIAL SECURITY NO. 217 01 5710		17. INFORMANT & ADDRESS Mrs Violet Kline, same as 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) CORONARY THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 5 MIN.	
ANTECEDENT CAUSE(S) DUE TO CORONARY INSUFFICIENCY						22 MOS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO CORONARY ARTERIOSCLEROSIS.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-25, 1954, to 6-13, 1956, that I last saw the deceased alive on 6-13, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE Leon C. Perry		M.D. 201 BLA BLVD. GLENBURNIE, MD.		DATE SIGNED 6-15-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/18/56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE L. J. Dealba		25. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		ADDRESS Hopping and Kirkley, Glen Burnie, Md.	
DATE June 16, 1956							

05185

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

CERTIFICATE OF DEATH

Date of Death

Place of Death

Age

Residence

Place of Birth

Race

Sex

Color

Date of Death

Place of Death

Age

Residence

BUREAU V. S.

MAY 19 1956

RECEIVED

Baltimore, Maryland

05185

1956

RECEIVED

5780

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville State Hosp.				c. LENGTH OF STAY IN 1b 1 yr. 5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hosp.				e. STREET ADDRESS 27 N. Carey St.			
3. NAME OF DECEASED (Type or print) Mattie First A. Middle Knox Last				4. DATE OF DEATH Month June Day 9 Year 19 56			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH ?	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.		10. AGE (In years last birthday) 81 yrs.		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Petersburg, Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas Matthews			
14. MOTHER'S MAIDEN NAME Catherine				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. No				17. INFORMANT Record, Crownsville State Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrenous right great toe, and mal-nutrition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from 1-1-55 to 6-9-56 , that I last saw the deceased alive on 6-9-56 , and that death occurred at 1:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ludwig Benedict</i>				ADDRESS (Street, city or town, state) 6-9-56 DATE SIGNED 6-12-56			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.				M.D. Crownsville State Hosp., Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/12/1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i>				ADDRESS Schneider St		24a. REC'D BY REGISTRAR 6-12-56	
24b. REGISTRAR'S SIGNATURE <i>Katherine M. Joyce</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1890		Baltimore		Maryland		United States		United States	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		RE-MARRIED		RE-MARRIED		RE-MARRIED	
DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH	
JANUARY 1, 1935		JANUARY 1, 1935		Baltimore		Maryland		United States		United States		United States		United States	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	
Heart Disease		Chest Pain		Shortness of Breath		Medicine		None		None		None		None	
Duration of Illness		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death		Time of Death	
2 Weeks		10:00 PM		10:00 PM		10:00 PM		10:00 PM		10:00 PM		10:00 PM		10:00 PM	
Physician		Physician		Physician		Physician		Physician		Physician		Physician		Physician	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
Signature		Signature		Signature		Signature		Signature		Signature		Signature		Signature	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
Date		Date		Date		Date		Date		Date		Date		Date	
JAN 1 1935		JAN 1 1935		JAN 1 1935		JAN 1 1935		JAN 1 1935		JAN 1 1935		JAN 1 1935		JAN 1 1935	
Place		Place		Place		Place		Place		Place		Place		Place	
Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	
State		State		State		State		State		State		State		State	
Maryland		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland		Maryland	
Country		Country		Country		Country		Country		Country		Country		Country	
United States		United States		United States		United States		United States		United States		United States		United States	

BUREAU V. 4

1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5741

CERTIFICATE OF DEATH

05757

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General Hospital</i>		d. STREET ADDRESS <i>412 Sixth St</i>	
3. NAME OF DECEASED (Type or print) First <i>CHARLES</i> Middle <i>H.</i> Last <i>KUTSCH</i>		4. DATE OF DEATH Month <i>June</i> Day <i>26</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 3, 1906</i>
9. AGE (In years) <i>50</i> yrs.		10. IF UNDER 1 YEAR: Months <i>30</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Stores</i>	
11. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Kutsch</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Crozier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Wife Madelyne E. Kutsch #2</i>	
17. INFORMANT Address <i>Wife Madelyne E. Kutsch #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X Congestive heart failure</i> DUE TO (b) <i>Nephrosis</i> DUE TO (c) <i>Arteriosclerotic nephrosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 mos</i> <i>15 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August</i> , 1955, to <i>26 June</i> , 1956, that I last saw the deceased alive on <i>26 June</i> , 1956, and that death occurred at <i>12:53 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John A. Haderwein</i>		ADDRESS (Street, city or town, state) <i>90 Cathedral St. Annapolis, Md.</i>	
DATE SIGNED <i>6/26/56</i>			
PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-29-1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Son Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>6/27/1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

NAME: *Charles H. Kitchin*
 SEX: *Male*
 AGE: *30*
 DATE OF BIRTH: *June 25, 1924*
 PLACE OF BIRTH: *Northampton, Mass.*
 OCCUPATION: *None*
 CAUSE OF DEATH: *Heart Disease*
 PLACE OF DEATH: *Northampton, Mass.*
 DATE OF DEATH: *June 25, 1954*
 SIGNATURE OF DECEASED: *Charles H. Kitchin*
 SIGNATURE OF WITNESSES: *Charles H. Kitchin*
 SIGNATURE OF PHYSICIAN: *Charles H. Kitchin*
 SIGNATURE OF REGISTRAR: *Charles H. Kitchin*

BUREAU OF VITAL RECORDS

JUN 28 1956

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05758

5742

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>79 Shipwright St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>WARREN</u> Last <u>LAJEUNESSE</u>				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-1902</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.		11. BIRTHPLACE (State or foreign country) <u>N. NEW PORTLAND ME.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rear Admiral U.S.N. RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. NAVY</u>			
13. FATHER'S NAME <u>Verne Lishness</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Paige</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1924</u>				16. SOCIAL SECURITY NO. <u>2</u>			
17. INFORMANT <u>Dorothy M. Lajeunesse</u>				Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Malignant hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u> <u>2 yrs.</u> <u>2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/3</u> , 19 <u>56</u> , to <u>6/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred on <u>7-20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Braden</u> M.D. <u>90 Cathedral St.</u>				DATE SIGNED <u>6/3/56</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sun Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>6/4/1956</u>		24b. REGISTRAR'S SIGNATURE <u>V. Daniel</u>	

BUREAU A. 3.

JUN 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05759	
Item 20 Film G200 7-2056 ams											
5743										Reg. Dist. No. 21	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MARTIN Last LAUSCH					4. DATE OF DEATH Month JUNE Day 15 Year 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1917		9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10b. KIND OF BUSINESS OR INDUSTRY Building construction			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Lausch					14. MOTHER'S MAIDEN NAME Ide Hittle						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 216-18-7943		17. INFORMANT Mr. John J. Lausch- Brother- Annapolis, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acc. Pulmonary Congestion & edema DUE TO Electrolyte imbalance Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 12 hrs. DUE TO 1 wk. (c) 1st exhaustion of extreme pregnancy 14/15 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No further information						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 14, 1956 to June 15, 1956 , that I last saw the deceased alive on June 14, 1956 , and that death occurred at 1:43A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Md DATE SIGNED 6/18/56											
ACTUAL SIGNATURE Maurice F. Klawans M.D.					PHYSICIAN'S NAME (Type) Maurice F. Klawans MD 31 Southgate Ave. Annapolis, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			22d. LOCATION (City, town, or county) (State) Annapolis, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home					ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR June 18, 56		24b. REGISTRAR'S SIGNATURE J. J. Lausch		

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

1956

Name of Deceased		Date of Death	
John A. Smith		June 1, 1956	
Age		Sex	
65		Male	
Race		Place of Birth	
White		Maryland	
Marital Status		Cause of Death	
Married		Heart Disease	
Occupation		Signature of Physician	
Teacher		[Signature]	
Place of Death		Date of Report	
Home		June 1, 1956	
Signature of Registrar		Signature of Medical Examiner	
[Signature]		[Signature]	
Date of Report		Date of Report	
June 1, 1956		June 1, 1956	

BUREAU A. 1

JUN 21 1956

RECEIVED

5781
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05760
Reg. Dist.
No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A.A. County</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>A.A. CO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mary - Rural.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>RURAL - Mary</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Clouery. Box 24</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>NORMAN.</u>	(Middle) <u>W.</u>	(Last) <u>LEE</u>	(Month) <u>6</u> (Day) <u>17</u> (Year) <u>19 56</u>
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M.</u>	8. DATE OF BIRTH: <u>Oct. 10, 1899</u>
9. AGE last birthday: <u>56</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Coal Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Coal</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William J. Lee</u>		14. MOTHER'S MAIDEN NAME: <u>Lilla Lusby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>1919</u>		16. SOCIAL SECURITY No.: <u>220-03-5171</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Dorothy Lee- Wife- same as # 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause <u>Chronic - Myocarditis</u>		<u>Sudden.</u>
(b) Antecedent cause(s) <u>DUE TO</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>DUE TO</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>E. J. Smith</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-16-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>20-56</u>	NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>
LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>	24. FUNERAL DIRECTOR <u>Hopping Funeral Home</u>	ADDRESS <u>Annapolis, Md.</u>
DATE REC'D BY LOCAL REG. <u>6-18-56</u>	RECEIVED BY SIGNATURE <u>J. J. Daniel</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

BUREAU A. E.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5744

CERTIFICATE OF DEATH

05761

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.		e. STREET ADDRESS 106 Eastern Ave.	
3. NAME OF DECEASED (Type or print) William Henry Clay Lewis		4. DATE OF DEATH Month June Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1869
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Lewis		14. MOTHER'S MAIDEN NAME Melvine Sewel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. U.S.N.	
17. INFORMANT Lawrence Albert Lewis		Address 211 Eastern Ave. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) anesthesia, operation (debridement of burn), (c) pneumonia, generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Third degree burns thighs, rt. leg; expired under anesthes			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps and spilled scalding water on self.	
20c. TIME OF INJURY Month, Day, Year Hour a. n. May 18 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, A.A., Md.	
21. I certify that I attended the deceased from May 18, 1956 , to June 25, 1956 , that I last saw the deceased alive on June 25, 1956 , and that death occurred at 10:33AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jesse L. Wilkins		DATE SIGNED 98 Cathedral St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) Jesse L. Wilkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/27/56	
22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Son		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR June 27, 1956		24b. REC'D BY REGISTRAR SIGNATURE J. O. Danach	

BUREAU V. S.

JUN 28 1955

REC'D & FILED
JUN 28 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5745

CERTIFICATE OF DEATH

Reg. Dist. No.

05762

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>				d. STREET ADDRESS <u>Truxton Heights</u>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>L.</u> Last <u>Lipinski</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Francis Lipinski</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kwiatkowski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Helen V. Lipinski</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>524X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anthracosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>3 1/2 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1953</u> , to <u>6/8/1956</u> , that I last saw the deceased alive on <u>6/8/1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____				DATE SIGNED <u>6/9/56</u>			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>63 College Ave</u>							
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>6-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Laybort Sons Chmarras, Md.</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>6-11-56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the body, and bring the body to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05763

Reg. Dist. No. 24

5782

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 3 years		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Same b. COUNTY Same		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 417 Delmar Avenue		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Ella Lockerman		First		Middle		Last		4. DATE OF DEATH June 27th.		Month		Day		Year 19 56	
5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/24/03		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Operator		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (State or foreign country) Lake Shore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME James Jubb		14. MOTHER'S MAIDEN NAME Effie L. Price													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-14-5575		17. INFORMANT Mrs. R. Groesser, 318 Murdock Rd. Towson, Md.		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage caused by a self inflicted 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) wound through the brain with a 38 calibre bullet. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot herself through the right temporal with a bullet.													
20c. TIME OF INJURY Month, Day, Year 9:55 A.M. 6/27/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (bed room)		20f. (City or town) Glen Burnie Md. A.A. Md.		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE Gustave H. Faubert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/27/56							
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.															
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) Glen Burnie Md.		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Dealba		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR July 2, 1956		24b. REGISTRAR'S SIGNATURE L. J. Dealba									

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

JUL 5 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5783

CERTIFICATE OF DEATH

05764

Reg. Dist. No. X3

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Anne Arundel</u>	MARYLAND		STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Linthicum Hgts.</u>	LENGTH OF STAY (in this place) <u>9 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Hgts.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>117 Sycamore Rd.</u>			STREET ADDRESS (If rural give location) <u>117 Sycamore Rd.</u>		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) <u>Patrick</u> (Middle) <u>Joseph</u> (Last) <u>Losco</u>			(Month) <u>June</u> (Day) <u>3</u> (Year) <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 8, 1900</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Refining Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Losco</u>			14. MOTHER'S MAIDEN NAME <u>Angelina Sippolini</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W-W-I & II</u>			16. SOCIAL SECURITY NO. <u>109-09-3225</u>		17. INFORMANT & ADDRESS <u>Mrs. Marjorie H. Losco Linthicum</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					18. MEDICAL CERTIFICATION
153X IMMEDIATE CAUSE (A) <u>Carcinoma of the cecum with</u>					INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases</u>					<u>10 mo.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1956</u> , to <u>June 3, 1956</u> , that I last saw the deceased alive on <u>June 3, 1956</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>C. Milton Linthicum</u>		ADDRESS (Street, city, town, state) <u>M.D. 106 W. Maple Rd. Linthicum Hgts.</u>		DATE SIGNED <u>6/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>June 7, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Stonefort Cemetery</u>		LOCATION (City, town, or county) (State) <u>Schoharie, New York</u>	
24. REC'D BY REGISTRAR <u>6/6/56</u>	REGISTRAR'S SIGNATURE <u>Dr. Caldwell Harduff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Long. L. L. L.</u>		ADDRESS <u>Glen Burnie, Md.</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05765

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5746

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anna Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anna Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
SADIE MARCELLAS				June 24 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Feb. 6, 1894	62 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife		own home		Owings, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James S. Catterton				Rose Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Clarence Marcellas, same as #2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
11437 IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						2 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cerebrovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>hypertension.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>droplets mellitus; fruit at hip</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6/6/58		Intest. hemorrhage fruit at hip					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		home		Uwings, Annapolis Md			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
2000 6/6/58 M.				fell.			
22. I hereby certify that I attended the deceased from Jan 19 55, to June 24, 19 58, that I last saw the deceased alive on June 23, 19 58, and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				DATE SIGNED <u>June 24, 19 58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/26/58		Mt Harmony		Owings Md	
24. REC'D BY REGISTRAR		REC'D BY REGISTRAR SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 6/25/58		[Signature]		[Signature]		[Address]	
6/28/58							

CERTIFICATE OF DEATH

5718

LOCAL BOARD OF HEALTH

City of Boston

Ward 1

Age 65

Male

65

1900

July 2

1956

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

RECEIVED

1

BUREAU V. 1

JUL 2 1956

RECEIVED

John J. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05766

5784

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayside Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayside Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Harbor Road				d. STREET ADDRESS 22 Harbor Road			
3. NAME OF DECEASED (Type or print) First ICIE (IDA) Middle MAY Last MARTIN				4. DATE OF DEATH Month June Day 16, Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1872	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William C. Kisner				14. MOTHER'S MAIDEN NAME Hannah Singleton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Edna R. Streett, 22 Harbor Road, Bayside Beach, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 Acute cardiac decompensation DUE TO (b) generalized arteriosclerosis DUE TO (c) not known						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 10, 1956 to June 16, 1956 that I last saw the deceased alive on June 15, 1956 and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin				M.D. Pasadena, Md DATE SIGNED June 16, 1956			
PHYSICIAN'S NAME (Type) R.M. McLAUGHLIN, M.D.				Pasadena, Md June 16, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Boyle, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE 6-19-56	
				24b. REGISTRAR'S SIGNATURE Louis J. DeAlba			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 - A OVER

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05767

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ac. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Matthew</u> Last <u></u>			4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-56</u>	
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>2</u> Days <u>28</u>			IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	
IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Charles Matthew</u>	14. MOTHER'S MAIDEN NAME <u>Lillian Griffin</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, war or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Lillian Griffin - Annapolis, Md</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 921.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Apnea Vomitus</u> (c) <u></u> (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ **Inspection** ☒ **Inquiry** ☐ **and find that death resulted from:** Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐

ACTUAL SIGNATURE <u>E. Linhardt</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>6-24-56</u>
EXAMINER'S NAME (Type) <u>B. LINHARDT</u>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) <u>Annapolis, Md</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md</u>	ADDRESS <u></u>	24a. REC'D BY REGISTRAR <u>June 27, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2039233405

JUN 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05768

5785

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 5 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 3 N. Vincent Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle McDonald Last McDonald				4. DATE OF DEATH Month 6 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/26/07	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Not given S.C.	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Not given Jesse McDonald				14. MOTHER'S MAIDEN NAME Not given Eddie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Address Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Toxemia IMMEDIATE CAUSE (a) 026X DUE TO (b) Multiple necrotic trophic ulcers of the skin DUE TO (c) Central Nervous System Syphilis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/17 , 19 56 , to 6/19 , 19 56 , that I last saw the deceased alive on 6/18 , 19 56 , and that death occurred at 1:45am , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/19/56			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/22/1956		22c. NAME OF CEMETERY OR CREMATORY Western Star		22d. LOCATION (City, town, or county) (State) Calumville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie K. Williams ADDRESS 322 N. Schroeder Baltimore, Md.				24a. REC'D BY REGISTRAR 6-21-06		24b. REGISTRAR'S SIGNATURE Katherine M. Joyce	

A34

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH			
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JUN 21 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		JUN 21 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS		GRANDPARENTS	
HEART DISEASE		SUICIDE		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		ONE		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JUN 21 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		JUN 21 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA	

BUREAU V. S.

JUN 21 1968

RECEIVED

5786

CERTIFICATE OF DEATH

Reg. Dist. 05768 ✓

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural Box 23 C</u>	
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>H.</u> Last <u>McINTYRE, SR.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Penal Institution Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James F. McIntyre</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gertrude McIntyre</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War 1 & 2</u> <u>none</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Gertrude L. McIntyre - Rural Box 23 C</u>		Address <u>Jessups, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis of throat + tongue</u> <u>145X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of tonsil.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1st</u> , 19 <u>56</u> , to <u>June 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>56</u> , and that death occurred at <u>2:40</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u>		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>		DATE SIGNED <u>6/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>June 30 1956</u>	
ADDRESS <u>17 N. ...</u>		24b. REGISTRAR'S SIGNATURE <u>R. Clara ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

1956 2 JUL

RECEIVED

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05770

5787

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ft. Meade</u>	LENGTH OF STAY (in this place) <u>5 1/2 hrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ft. Meade</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S.A.H. Ft. Meade</u>		STREET ADDRESS (If rural give location) <u>US ARMY HOSPITAL</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>28</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>27 JUNE 1956</u>	
9. AGE last birthday <u>5 hr 30 min</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOWARD M. MEYERS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH L. KELLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Father: 1106 S. Highland Ave., Balto., Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>776x Prematurity</u>		PREMATURITY	
ANTECEDENT CAUSE(S) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>5hrs 30 min</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST, DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 June 1956</u> to <u>28 June 1956</u>, that I last saw the deceased alive on <u>28 June 1956</u>, and that death occurred at <u>3:00 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>Michael A. Dobridge</u>		DATE SIGNED <u>28 June 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>W.L. SAYLOR, 1/Lt MSC</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>WM. S. FIALKOWSKI, BALTO., Md.</u>		ADDRESS <u>12101 Disney Dr, Silver Spring, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. SEX

11. AGE

12. OCCUPATION

13. CAUSE OF DEATH

14. DATE OF DEATH

15. TIME OF DEATH

16. PLACE OF BIRTH

17. DATE OF BIRTH

18. SEX

19. AGE

20. OCCUPATION

21. CAUSE OF DEATH

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF BIRTH

25. DATE OF BIRTH

26. SEX

27. AGE

28. OCCUPATION

29. CAUSE OF DEATH

30. DATE OF DEATH

31. TIME OF DEATH

32. PLACE OF BIRTH

33. DATE OF BIRTH

34. SEX

35. AGE

36. OCCUPATION

37. CAUSE OF DEATH

38. DATE OF DEATH

39. TIME OF DEATH

40. PLACE OF BIRTH

41. DATE OF BIRTH

42. SEX

43. AGE

44. OCCUPATION

45. CAUSE OF DEATH

46. DATE OF DEATH

47. TIME OF DEATH

48. PLACE OF BIRTH

49. DATE OF BIRTH

50. SEX

51. AGE

52. OCCUPATION

53. CAUSE OF DEATH

54. DATE OF DEATH

55. TIME OF DEATH

56. PLACE OF BIRTH

57. DATE OF BIRTH

58. SEX

59. AGE

60. OCCUPATION

61. CAUSE OF DEATH

62. DATE OF DEATH

63. TIME OF DEATH

64. PLACE OF BIRTH

65. DATE OF BIRTH

66. SEX

67. AGE

68. OCCUPATION

69. CAUSE OF DEATH

70. DATE OF DEATH

71. TIME OF DEATH

72. PLACE OF BIRTH

73. DATE OF BIRTH

74. SEX

75. AGE

76. OCCUPATION

77. CAUSE OF DEATH

78. DATE OF DEATH

79. TIME OF DEATH

80. PLACE OF BIRTH

81. DATE OF BIRTH

82. SEX

83. AGE

84. OCCUPATION

85. CAUSE OF DEATH

86. DATE OF DEATH

87. TIME OF DEATH

88. PLACE OF BIRTH

89. DATE OF BIRTH

90. SEX

91. AGE

92. OCCUPATION

93. CAUSE OF DEATH

94. DATE OF DEATH

95. TIME OF DEATH

96. PLACE OF BIRTH

97. DATE OF BIRTH

98. SEX

99. AGE

100. OCCUPATION

101. CAUSE OF DEATH

BUREAU V. 1

JUL 2 1956

RECEIVED

RECEIVED

5748

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>3808 13th St - Brooklyn - MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn - MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D. O. ANNE ARUND. GENERAL.</u>		d. STREET ADDRESS <u>3808 3RD ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>D. Migliorini</u> Middle <u>D.</u> Last <u>Migliorini</u>		4. DATE OF DEATH <u>June 8 1986</u> Month <u>June</u> Day <u>8</u> Year <u>1986</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 27, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Davidson Chemical</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dominic Migliorini</u>		14. MOTHER'S MAIDEN NAME <u>LUCIA FURLENI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>215-07-7527</u>	
17. INFORMANT <u>VINCENT MIGLIORINI</u>		Address <u>320 WASHBURN AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> DUE TO <u>434.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>_____</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 8</u> , 19 <u>86</u> , to <u>JUNE 8</u> , 19 <u>86</u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>86</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Baltimore, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>E. Linhardt.</u>		DATE SIGNED <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/11/86</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Jones</u>		ADDRESS <u>4001 RITCHIE HWY</u>	
24a. REC'D BY REGISTRAR <u>6-13-86</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5788

CERTIFICATE OF DEATH

Reg. Dist. No.

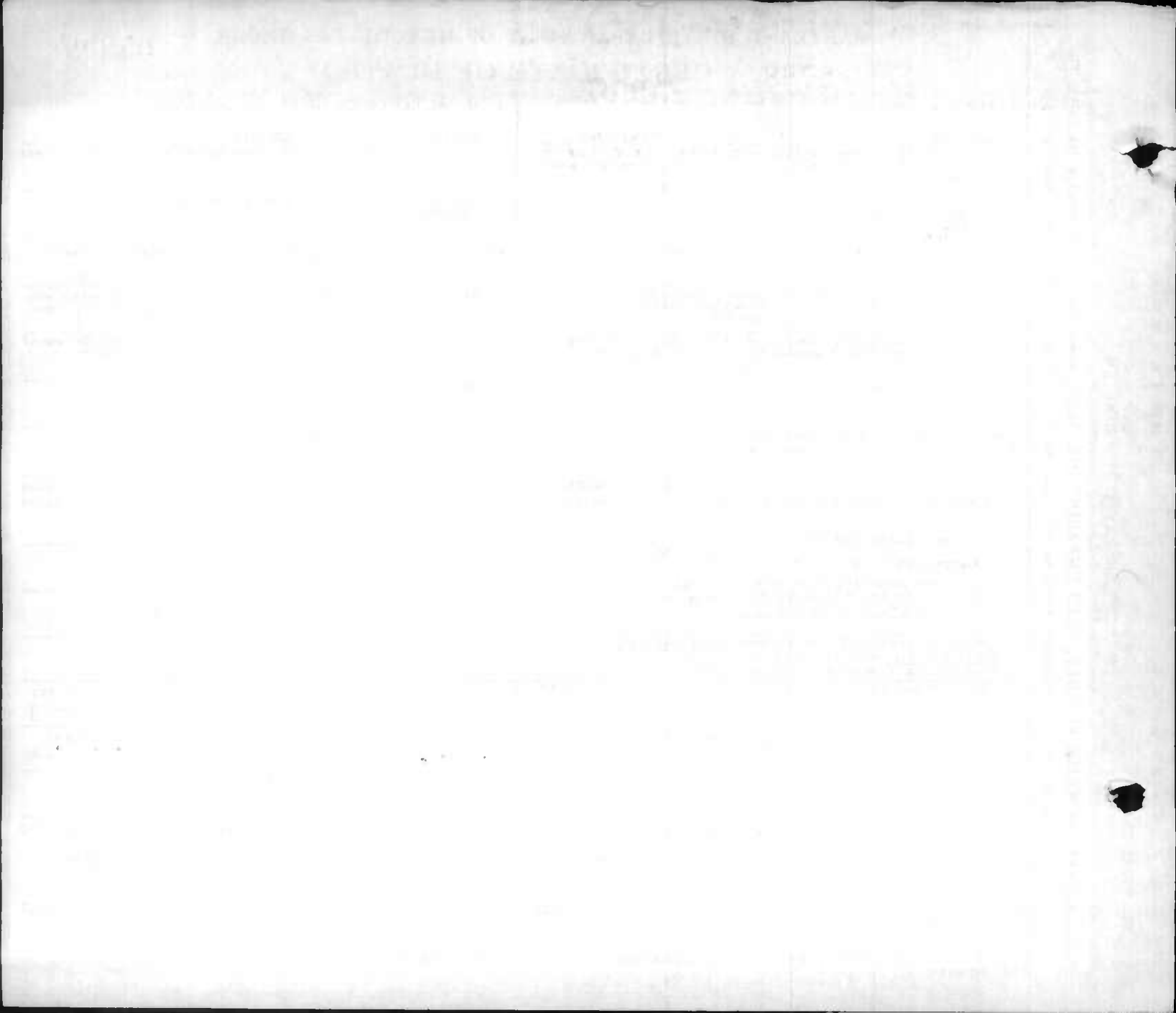
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correct age is especially.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. NAME OF DECEASED (Type or Print) VINCENZO MOSCO <i>Vincenzo Mosco</i>		2. DATE OF DEATH 6/6/56	
3. PLACE OF DEATH A. Baltimore City, Maryland <i>a.d. Co.</i>		4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE <i>Md.</i> COUNTY <i>a.d.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Rural</i> 422 Church Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> 25	
c. Length of stay in Baltimore Yrs. <i>Yrs.</i> Mos. <i>Mos.</i> Days <i>Days</i>		D. STREET ADDRESS (If rural, give location) 122 Church St	
5. SEX <i>m.</i>	6. COLOR OR RACE <i>w.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>unmarried</i>	8. DATE OF BIRTH 7-19-1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>stonemason</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years; last birthday) 69
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Antonio Mosco</i> MOSCO		14. MOTHER'S MAIDEN NAME <i>Alicia Clairini</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. 206-05-8609	
17. INFORMANT <i>Mosco</i>		ADDRESS <i>Chiara Mosco - name</i>	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2nd	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Total Heart Block (Aortic Atherosclerosis)		DUE TO 9 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary sclerosis (aortic) Lilitosis		DUE TO e	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION At work	
20. AUTOPSY? <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Sept. 1956 to June 5, 1956 , that I last saw the deceased alive on June 1, 1956 , and that death occurred at 345 years, from the causes and on the date stated above.			
23A. SIGNATURE <i>H. S. Summers</i>		23B. ADDRESS 110106 Yappa Ave	
23C. DATE SIGNED 6.6.56			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/8/56	24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.
DATE RECEIVED BY LOCAL REGISTRAR 6-7-56	REGISTRAR'S SIGNATURE <i>H. S. Summers</i>	25. FUNERAL DIRECTOR McCully Funeral Hm. 130 E. Fort Ave.	
REGISTRAR			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05772

Item 8, Film G198 6-18-56 et

5749

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>a a</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>62 yrs</u>		TOWN <u>Bristol</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>a a General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Russell</u> (Middle) <u>Moreland</u> (Last)				(Month) <u>June</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Bristol Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>W M E. Moreland</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN MORELAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary S Moreland, Bristol Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Cerebral embolus</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>56</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city, town, state) <u>Lothian, Md.</u>		DATE SIGNED <u>6/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) <u>Lothian Md</u>	
24. REC'D BY REGISTRAR <u>J. J. Donnell</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Salisbury Md</u>	
DATE <u>6-13-1956</u>							

CERTIFICATE OF DEATH

1. PLACE OF BIRTH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DEATH CERTIFICATE OFFICER

13. SIGNATURE OF DEATH CERTIFICATE OFFICER

14. SIGNATURE OF DEATH CERTIFICATE OFFICER

15. SIGNATURE OF DEATH CERTIFICATE OFFICER

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18. SIGNATURE OF DEATH CERTIFICATE OFFICER

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27. SIGNATURE OF DEATH CERTIFICATE OFFICER

28. SIGNATURE OF DEATH CERTIFICATE OFFICER

29. SIGNATURE OF DEATH CERTIFICATE OFFICER

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32. SIGNATURE OF DEATH CERTIFICATE OFFICER

33. SIGNATURE OF DEATH CERTIFICATE OFFICER

34. SIGNATURE OF DEATH CERTIFICATE OFFICER

35. SIGNATURE OF DEATH CERTIFICATE OFFICER

BUREAU V. 1

JUN 14 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

1

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05773

5789

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>New Cut Road</u>				d. STREET ADDRESS <u>New Cut Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth Long</u> Middle <u>Mumford</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>9th.</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/27/11</u>		9. AGE (In years last birthday) <u>44</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Mumford</u>				14. MOTHER'S MAIDEN NAME <u>Julia King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Navy 1942-46</u>		17. INFORMANT Address <u>Mrs. Alma Mumford (Wife.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 10/1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u>				ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara Haslop</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
Baltimore, Maryland

BUREAU A. 1

JUN 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5750

CERTIFICATE OF DEATH

05774

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>5 Dale Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Catherine Norman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 19 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 18, 1956</u>	9. AGE last birthday yrs. <u>—</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Norman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McFadden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral tumor</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Brain atrophy</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-18</u> , 19 <u>56</u> , to <u>6-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>56</u> , and that death occurred at <u>4:25 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Benjamin A. Riley Jr.</u> ADDRESS (Street, city, town, state) <u>6-20-56.</u> DATE SIGNED <u>M.D.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 22 56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 22, 56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>	

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1956

June 25, 1956

IN REGISTRATION OF DEATHS

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BUREAU V. 1

JUN 25 1956

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REGISTRATION OF DEATHS

1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5790

CERTIFICATE OF DEATH

Reg. Dist. No.

05275

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R.F.D. 1, Box 264 A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Oktavec, Sr.				4. DATE OF DEATH Month June Day 2 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1884		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Oktavec				14. MOTHER'S MAIDEN NAME Marie Blaha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219p32-0818		17. INFORMANT Address Wm. A. Oktavec, Jr., 3613 Lyndale Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260.1 (b) Hypertension DUE TO (c) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 1/2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 18, 1949 , to June 2, 1956 , that I last saw the deceased alive on June 2, 1956 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin M.D.				ADDRESS (Street, city or town, state) Pasadena, Md.		DATE SIGNED June 2, 1956	
PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D.				ADDRESS Pasadena, Md.		DATE June 2, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601 3-5 E. Madison St.				24a. REC'D BY REGISTRAR 4/6/56		24b. REGISTRAR'S SIGNATURE L.G. DeAlba	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JONES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF DEATH June 5, 1950	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural		11. PLACE OF DEATH Home		12. SIGNATURE OF PHYSICIAN J. J. Jones	
13. SIGNATURE OF DECEASED John J. Jones		14. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		15. SIGNATURE OF CLERK J. J. Jones		16. SIGNATURE OF REGISTRAR J. J. Jones	
17. SIGNATURE OF DECEASED John J. Jones		18. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		19. SIGNATURE OF CLERK J. J. Jones		20. SIGNATURE OF REGISTRAR J. J. Jones	
21. SIGNATURE OF DECEASED John J. Jones		22. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		23. SIGNATURE OF CLERK J. J. Jones		24. SIGNATURE OF REGISTRAR J. J. Jones	
25. SIGNATURE OF DECEASED John J. Jones		26. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		27. SIGNATURE OF CLERK J. J. Jones		28. SIGNATURE OF REGISTRAR J. J. Jones	
29. SIGNATURE OF DECEASED John J. Jones		30. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		31. SIGNATURE OF CLERK J. J. Jones		32. SIGNATURE OF REGISTRAR J. J. Jones	
33. SIGNATURE OF DECEASED John J. Jones		34. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		35. SIGNATURE OF CLERK J. J. Jones		36. SIGNATURE OF REGISTRAR J. J. Jones	
37. SIGNATURE OF DECEASED John J. Jones		38. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		39. SIGNATURE OF CLERK J. J. Jones		40. SIGNATURE OF REGISTRAR J. J. Jones	
41. SIGNATURE OF DECEASED John J. Jones		42. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		43. SIGNATURE OF CLERK J. J. Jones		44. SIGNATURE OF REGISTRAR J. J. Jones	
45. SIGNATURE OF DECEASED John J. Jones		46. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		47. SIGNATURE OF CLERK J. J. Jones		48. SIGNATURE OF REGISTRAR J. J. Jones	
49. SIGNATURE OF DECEASED John J. Jones		50. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		51. SIGNATURE OF CLERK J. J. Jones		52. SIGNATURE OF REGISTRAR J. J. Jones	
53. SIGNATURE OF DECEASED John J. Jones		54. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		55. SIGNATURE OF CLERK J. J. Jones		56. SIGNATURE OF REGISTRAR J. J. Jones	
57. SIGNATURE OF DECEASED John J. Jones		58. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		59. SIGNATURE OF CLERK J. J. Jones		60. SIGNATURE OF REGISTRAR J. J. Jones	
61. SIGNATURE OF DECEASED John J. Jones		62. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		63. SIGNATURE OF CLERK J. J. Jones		64. SIGNATURE OF REGISTRAR J. J. Jones	
65. SIGNATURE OF DECEASED John J. Jones		66. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		67. SIGNATURE OF CLERK J. J. Jones		68. SIGNATURE OF REGISTRAR J. J. Jones	
69. SIGNATURE OF DECEASED John J. Jones		70. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		71. SIGNATURE OF CLERK J. J. Jones		72. SIGNATURE OF REGISTRAR J. J. Jones	
73. SIGNATURE OF DECEASED John J. Jones		74. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		75. SIGNATURE OF CLERK J. J. Jones		76. SIGNATURE OF REGISTRAR J. J. Jones	
77. SIGNATURE OF DECEASED John J. Jones		78. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		79. SIGNATURE OF CLERK J. J. Jones		80. SIGNATURE OF REGISTRAR J. J. Jones	
81. SIGNATURE OF DECEASED John J. Jones		82. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		83. SIGNATURE OF CLERK J. J. Jones		84. SIGNATURE OF REGISTRAR J. J. Jones	
85. SIGNATURE OF DECEASED John J. Jones		86. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		87. SIGNATURE OF CLERK J. J. Jones		88. SIGNATURE OF REGISTRAR J. J. Jones	
89. SIGNATURE OF DECEASED John J. Jones		90. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		91. SIGNATURE OF CLERK J. J. Jones		92. SIGNATURE OF REGISTRAR J. J. Jones	
93. SIGNATURE OF DECEASED John J. Jones		94. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		95. SIGNATURE OF CLERK J. J. Jones		96. SIGNATURE OF REGISTRAR J. J. Jones	
97. SIGNATURE OF DECEASED John J. Jones		98. SIGNATURE OF WITNESSES J. J. Jones, J. J. Jones		99. SIGNATURE OF CLERK J. J. Jones		100. SIGNATURE OF REGISTRAR J. J. Jones	

BUREAU V. S.

JUN 6 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05776

5791

CERTIFICATE OF DEATH

Reg. Dist. No.

73

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY a.a.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 S. Camp Meade Rd.		d. STREET ADDRESS 200 S. Camp Meade Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Pfeiffer		4. DATE OF DEATH Month June Day 29 Year 56	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Amos Earp		14. MOTHER'S MAIDEN NAME Marian Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nicholas Albert Pfeiffer		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage (multiple, small) DUE TO (c) Arteriosclerotic Heart Disease - Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 1950, to June 29 , 1956, that I last saw the deceased alive on June 26 , 1956, and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Milton Linthicum M.D.		ADDRESS (Street, city or town, state) Linthicum Heights Rd DATE SIGNED 6/29/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2/56	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR July 2, 1956		24b. REGISTRAR'S SIGNATURE Dr. Caldwell Woodruff	

CERTIFICATE OF DEATH

5701

COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF NEXT OF KIN [Illegible]	
SIGNATURE OF BURIAL OFFICER [Illegible]		SIGNATURE OF CHURCH OFFICER [Illegible]	
SIGNATURE OF MINISTER [Illegible]		SIGNATURE OF CLERGYMAN [Illegible]	
SIGNATURE OF RABBI [Illegible]		SIGNATURE OF OTHER [Illegible]	

BUREAU V. 8

JUL 3 1956

RECEIVED

RECEIVED
JUL 3 1956
BUREAU V. 8

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05777

Reg. Dist. No. 21

5751

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>30 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pronounced dead at A. A. Gen. Hosp. 7th. Dist. Rescue Squad Amb.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Infant Phipps</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 13 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 13 1956</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alton Joseph Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Etta Jeanette Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Alton J. Phipps, Deale Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>776x Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Delevery, 12</u> to <u>13 June</u>, 19<u>56</u>, that I last saw the deceased alive on <u>13 June</u>, 19<u>56</u>, and that death occurred at <u>5 A</u>.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>June 19 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>[Signature]</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>[Address]</u>			

1000382XV

CERTIFICATE OF DEATH

5751

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years and Months)

4. Date of birth (Month, Day, Year)

5. Date of death (Month, Day, Year)

6. Place of death (City, State, Country)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Signature of physician (Print name)

11. Signature of registrar (Print name)

12. Signature of medical examiner (Print name)

13. Signature of coroner (Print name)

14. Signature of funeral director (Print name)

15. Signature of health officer (Print name)

16. Signature of registrar (Print name)

17. Signature of medical examiner (Print name)

18. Signature of coroner (Print name)

19. Signature of funeral director (Print name)

20. Signature of health officer (Print name)

BUREAU V. 3

JUN 21 1956

RECEIVED

NOTIFICATION

1. Name of deceased (Print or write full name)
2. Sex (Male or Female)
3. Age (Years and Months)
4. Date of birth (Month, Day, Year)
5. Date of death (Month, Day, Year)
6. Place of death (City, State, Country)
7. Cause of death (Immediate cause)
8. Cause of death (Underlying cause)
9. Cause of death (Contributing cause)
10. Signature of physician (Print name)
11. Signature of registrar (Print name)
12. Signature of medical examiner (Print name)
13. Signature of coroner (Print name)
14. Signature of funeral director (Print name)
15. Signature of health officer (Print name)
16. Signature of registrar (Print name)
17. Signature of medical examiner (Print name)
18. Signature of coroner (Print name)
19. Signature of funeral director (Print name)
20. Signature of health officer (Print name)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5752

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick C. Pocock</u>		4. DATE OF DEATH Month Day Year <u>June 14 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-10, 1890</u>
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (ret.)</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Casualty</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>Charles Pocock</u>		14. MOTHER'S MAIDEN NAME <u>Annie Voelker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-2162</u>	
17. INFORMANT <u>Mrs. Esther Pocock</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Two-to-one heart block</u> DUE TO (c) <u>Interventricular Cardiac Vascular Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>June 14 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 13 1956</u> to <u>June 14 1956</u> that I last saw the deceased alive on <u>June 14 1956</u> , and that death occurred at <u>9:28 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		DATE SIGNED <u>June 6/15/56</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried June 18, 1956</u>		22b. DATE THEREOF <u>June 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. French</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. French</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3-A OVER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5792

CERTIFICATE OF DEATH

05779

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>St. Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones station</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jones Station</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Powell</u> Middle <u>Powell</u> Last				4. DATE OF DEATH <u>June</u> Month <u>1</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colore</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Petersburg Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard E. Powell</u>				14. MOTHER'S MAIDEN NAME <u>Olga Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Isaiah Powell</u> Address <u>Jones Station</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Congestive Failure</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-4-55</u> , 19 <u>55</u> , to <u>6-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-26-56</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. Alley</u> M.D. <u>62 Cathedral St</u>				ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>6-2-56</u>			
PHYSICIAN'S NAME (Type) <u>A. J. ALLEY</u>				<u>62 CATHEDRAL ST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Earleights</u>		22d. LOCATION (City, town, or county) (State) <u>Jones Station, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>--34 Lafayette Ave. Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>6-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. 3

JUN 5 1956

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22, Film G199 6-27-56 et

5793

CERTIFICATE OF DEATH

05780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 23 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Alfred Middle Harrison Last Pumphrey		4. DATE OF DEATH Month 6 Day 13 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/89
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 24 HRS. Months - Days - Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Not given	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubital ulcers DUE TO (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 months 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/5 , 19 55 , to 6/13 , 19 56 , that I last saw the deceased alive on 6/13 , 19 56 , and that death occurred at 7:45 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/14/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann Arlington, Nat. Arlington, Va.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) 6/18/56		22b. DATE THEREOF 6/18/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l		22d. LOCATION (In city or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Smullen Rux Hall, Jr.		24a. REC'D BY REGISTRAR JUN 18 1956	
24b. REGISTRAR'S SIGNATURE Prathome M. Joyce			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1900		New York City		123 Main St.		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Death		Place of Death		Physician's Name		Hospital Name		Burial Place	
Teacher		High School		Married		Jan 15, 1945		New York City		Dr. J. Smith		St. Mary's Hospital		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JAN 18 1956

RECEIVED

Handwritten signature: Hilgard Kearsley

Handwritten signature: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05781

5794

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsmere Shores</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Groth Drive</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsmere Shores</u> d. STREET ADDRESS <u>Groth Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clifton Edward Rawlings</u> First Middle Last 4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 12, 1916</u> 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy</u> 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clifton E. Rawlings, Sr.</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Melvina D. Rawlings</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound - Suicide</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Suicide - 22 Cal. Rifle -</u> 20c. TIME OF INJURY Month, Day, Year <u>June 10 1956</u> Hour <u>1</u> a. m. <u>15</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Annapolis</u> (County) <u>MD</u> (State) <u>MD</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>E. Linhardt</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/10/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-13-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u> 22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u> 24a. REC'D BY REGISTRAR <u>6-11-56</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU A. S.

1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5753

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospt.		d. STREET ADDRESS 16 German St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last REYNOLDS		4. DATE OF DEATH Month June Day 6 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1900
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician U.S. & S. Steel		10b. KIND OF BUSINESS OR INDUSTRY Electrician	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. WWI	
17. INFORMANT Irene M. Reynolds #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acc. Coronary Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c) Severe Diabetes Mellitus			
INTERVAL BETWEEN ONSET AND DEATH 1 hr. yes. yes.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1949 , to June 6, 1956 , that I last saw the deceased alive on June 6, 1956 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis Md 6/7/56 DATE SIGNED _____			
ACTUAL SIGNATURE Maurice F. Klawans M.D. Annapolis Md 6/7/56			
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/56	
22c. NAME OF CEMETERY OR CREMATORY Edwards Chapel		22d. LOCATION (City, town, or county) (State) Parole Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons		ADDRESS Annapolis, Md	
24a. REC'D BY REGISTRAR DATE 6/8/1956		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4/ may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05783

Reg. Dist. No. 22

5795

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton c. LENGTH OF STAY IN 1b 1 1/2 day. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Partisan/Vd. In an automobile				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE Texas COUNTY Box-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Pleasant d. STREET ADDRESS 220 Steven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Allen Robb				4. DATE OF DEATH Month Day Year June 9th. 1956 19			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/13/81	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Government Clerk.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kenney, Illinois.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William T. Robb				14. MOTHER'S MAIDEN NAME Welthy Lowry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J.A. Robb (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/13/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
23. FUNERAL DIRECTOR'S SIGNATURE James A. Kirkley				24a. REC'D BY REGISTRAR 6-13-56		24b. REGISTRAR'S SIGNATURE Clara Neelup	
25. ADDRESS Hopping and Kirkley, Glen Burnie, Md.				26. LOCATION (City, town, or county) (State) Prince Georges Co.; Md.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. 2

JUN 13 1956

RECEIVED

6/13/56

REPORT OF DEATH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5796 CERTIFICATE OF DEATH

05784

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort George G. Meade</u>		<u>10 Months</u>		TOWN <u>Camden</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>33 S. Main Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MURRAY</u> (Middle) <u>SAPOFF</u> (Last)				(Month) <u>27 June</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>15 October 1912</u>	<u>43</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Soldier</u>		<u>U. S. Army</u>		<u>Latvia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>11 years 7 months</u>		<u>Unknown</u>		<u>Army Service Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.1</u>				<u>Coronary artery occlusion</u>		<u>4 Hours</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Arteriosclerosis</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not white <input type="checkbox"/>					
		M. at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>27 June</u> , 19 <u>56</u> , to <u>27 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 June</u> , 19 <u>56</u> , and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Michael A. Dobridge</u>		MICHAEL A. DOBRIDGE, MD.		ADDRESS (Street, city, town, state) <u>1201 Bushey Drive, Wheaton, Md.</u>		DATE SIGNED <u>27 June 56</u>	
		M.D. <u>1201 Bushey Dr. Wheaton, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Unk</u>		<u>Unk</u>		<u>New York</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<u>William Cook Inc</u>		<u>Balto, Md</u>	
DATE <u>28 June 1956</u>		W.L. SAYLOR, 1ST LT, MSC					

CERTIFICATE OF DEATH

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

CAUSE OF DEATH
 (To be filled by the physician or other person having knowledge of the cause of death)

PREVIOUS ILLNESS
 (To be filled by the physician or other person having knowledge of the cause of death)

DIAGNOSIS
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY
 (To be filled by the physician or other person having knowledge of the cause of death)

SIGNATURE OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

SIGNATURE OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

SIGNATURE OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF PHYSICIAN
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF DECEASED
 (To be filled by the physician or other person having knowledge of the cause of death)

TESTIMONY OF WITNESSES
 (To be filled by the physician or other person having knowledge of the cause of death)

BUREAU V. 2

JUL 3 1922

RECEIVED

NO 20 June 1926

5797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundle</u>	MARYLAND	STATE <u>Ma</u>	COUNTY <u>RA</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patasco Park</u>	LENGTH OF STAY (in this place) <u>35 Yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patasco Park</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>219 Bolivar Ave</u>		STREET ADDRESS (If rural give location) <u>219 Bolivar Ave</u> /	

3. NAME OF DECEASED: (First) (Middle) (Last) <u>Bertie Scott</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>6</u> <u>30</u> <u>1956</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-2-06</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>	
13. FATHER'S NAME: <u>William Scott</u>			14. MOTHER'S MAIDEN NAME: <u>Josephine McConider</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS: <u>Alice Reynolds</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Septic Infection</u>	
ANTECEDENT CAUSE (B)	<u>Septicemia</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	<u>Leg ulcers</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 18 1956 to June 30 1956, that I last saw the deceased alive on June 18 1956, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS Box 212 El Dorado Md DATE SIGNED [Signature]

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-3-56</u>	<u>Carver Mem</u>	<u>Howard County</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>7/3/56</u>	<u>G. W. Hedrick</u>	<u>Eliam J. Wilson</u>	<u>[Address]</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPORT OF THE COMMISSIONER OF AGRICULTURE

ANNUAL REPORT OF THE COMMISSIONER OF AGRICULTURE
FOR THE YEAR 1900

THE DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

1901

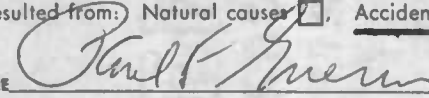
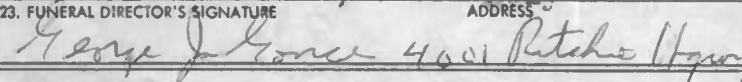
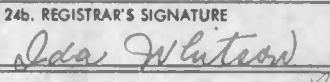
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05786

5798

Reg. Dist. No. 35

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Grove Rd.				d. STREET ADDRESS 638 Creswell Road Hammonds Lane -			
3. NAME OF DECEASED (Type or print) First August Middle R. Last Seifert				4. DATE OF DEATH Month 6 Day 1 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH May 4, 1908		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coast Guard Emp.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Coast Gd.		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.			
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME John J. Seifert				14. MOTHER'S MAIDEN NAME Sophia Rubezch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Josephine Kosmicki Seifert Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto					
20c. TIME OF INJURY Month, Day, Year Hour 10:45 a.m. 6 1 19 56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
20f. (City or town) N. Anne Arundel Md.		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/1/56			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Boys Cross			
22d. LOCATION (City, town, or county) Anne Arundel CO. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS 4001 Ritchie Hwy		24a. REC'D BY REGISTRAR DATE 6-11-56			
24b. REGISTRAR'S SIGNATURE 							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Name of Deceased Anna Arndel		Sex Female	
Age 18		Race White	
Date of Death June 11, 1956		Place of Death Bellevue	
City of Death Baltimore		County of Death Baltimore	
State of Death Maryland		Manner of Death Suicide	
Cause of Death Overdose of Barbiturates		Contributing Cause None	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]	

Investigation struck by auto

BUREAU V. 2
J. Arndel, MD.

JUN 11 1956

RECEIVED
JUN 11 1956

Paul J. [Signature]

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 4, Film 6-25-56 et

05787

5799

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>		LENGTH OF STAY (in this place) <u>46 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>417 Third St</u>				STREET ADDRESS (If rural give location) <u>417 Third St</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JAMES A. SMITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 14, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 27 1882</u>	
9. AGE last birthday <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchman</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wm H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Julia A. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-52-3067</u>		17. INFORMANT & ADDRESS <u>Caroline M. Smith</u>			
18. MEDICAL CERTIFICATION		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>		ANTECEDENT CAUSE(S) DUE TO		<u>1 hr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		(B) areteriosclerotic cardiovascular disease.		<u>15 yrs.</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>March 19 55</u> , to <u>June 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Amos Garrett</u>				ADDRESS (Street, city, town, state) <u>Amos Garrett Blvd., Annapolis, Md.</u>			
DATE SIGNED <u>6/18/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>6/18/1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard H. [Signature]</u>		ADDRESS <u>[Address]</u>	

SHORTCUTS

When the following instructions are followed, the Bureau will receive the maximum benefit from the use of the "SHORTCUTS" system. The instructions are as follows: 1. The "SHORTCUTS" system is a simplified method of filing and retrieving documents. 2. It is based on the use of a few key words and a few simple rules. 3. It is designed to save time and space. 4. It is easy to learn and use. 5. It is a valuable tool for anyone who deals with a large volume of documents. 6. It is a must for anyone who wants to get the most out of their filing system. 7. It is a simple, efficient, and effective way to organize and retrieve information. 8. It is a system that works. 9. It is a system that is easy to use. 10. It is a system that is worth the effort.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

James A. Smith

BUREAU A. 1

JUN 20 1956

RECEIVED

CERTIFICATE OF DEATH

5800

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Lebanon</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade</u>		LENGTH OF STAY (in this place) <u>4 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lebanon</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>231 South 10th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>STEPHEN</u> (Middle) <u>MICHAEL</u> (Last) <u>SNYDER</u>				(Month) <u>June</u> (Day) <u>27</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>18 November 55</u>	9. AGE last birthday yrs. <u>7</u> Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Clara L Nepi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother, 207 Glen Road Glen Burnie, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>754.4</u> <u>Congestive Heart Failure</u>				<u>Congestive Heart Failure</u>		<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGENITAL HEART DISEASE</u>				<u>CONGENITAL HEART DISEASE</u>		<u>7 Mon 9 Days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 May</u> , 19 <u>56</u> , to <u>27 June</u> , 19 <u>56</u> that I last saw the deceased alive on <u>27 June</u> , 19 <u>56</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needleman</u>		M. D. <u>USAH, Fort G.G. Meade, Md. 27 June 1956</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Unknown</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lebanon, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt, MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thompsons Funeral Home, Lebanon, Pa.</u>			
DATE <u>27 Jun 56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Cause of Death

6. Date of Death

7. Time of Death

8. Place of Death

9. Name of Physician

10. Name of Coroner

11. Name of Registrar

12. Name of Hospital

13. Name of Cemetery

14. Name of Burial Place

15. Name of Undertaker

16. Name of Funeral Home

17. Name of Mortuary

18. Name of Embalmer

19. Name of Transporter

20. Name of Interment

21. Name of Burial

22. Name of Burial

23. Name of Burial

24. Name of Burial

25. Name of Burial

26. Name of Burial

27. Name of Burial

28. Name of Burial

29. Name of Burial

30. Name of Burial

31. Name of Burial

32. Name of Burial

33. Name of Burial

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35. Name of Burial

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48. Name of Burial

49. Name of Burial

50. Name of Burial

51. Name of Burial

52. Name of Burial

53. Name of Burial

54. Name of Burial

55. Name of Burial

56. Name of Burial

57. Name of Burial

BUREAU V. 2

JUN 29 1956

RECEIVED

5801

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carvel				d. STREET ADDRESS Carvel Rd.			
3. NAME OF DECEASED (Type or print) First Norman Middle Stadiger Last Stadiger				4. DATE OF DEATH Month 6 Day 12 Year 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/84		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) /Realter		10b. KIND OF BUSINESS OR INDUSTRY Self - Emp.		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 , to June 12 1956 , that I last saw the deceased alive on June 11, 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riviera Beach, Md. DATE SIGNED 6/13/56							
ACTUAL SIGNATURE J. Brady Smith M.D.		PHYSICIAN'S NAME (Type) J. BRADY SMITH RIVIERA BEACH, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 6/15/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Louis J. De Alba	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

107712

C. 1987

READ V.

9551-87-13

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please eye-
cure the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation
or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn River</u>		c. LENGTH OF STAY IN 1b <u>3Y 01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2021 Fleet</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph F. Stapleton</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30-1932</u>
9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Stapleton</u>		14. MOTHER'S MAIDEN NAME <u>Edith Snook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Betty Staples</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850X</u> DUE TO <u>DROWNING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown out of boat while making turn</u>	
20c. TIME OF INJURY Month, Day, Year <u>AM 6-24 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Severn River</u>		20f. (City or town) <u>AA Co MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elmer Linhardt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ELMER LINHARDT</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newbury Baptist</u>		22d. LOCATION (City, town, or county) <u>Cassville PA</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc 1217 St. Paul St</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Ashby</u>	
24a. REC'D BY REGISTRAR <u>26 1956</u>			

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John
1931

Q. Q.

John

Ralph F. Stobbs
1931

John

John Stobbs

John Stobbs
DROWNED

John Stobbs

AM 6-24 32

✓

JUN 28 1956

RECEIVED

ELMER KINARD

11-1001 W.C. 117 of 1956

05791

5893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 12yrs. 8mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irving Middle (Sheldon) Last Stark				4. DATE OF DEATH Month 6 Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not known	
9. AGE (In years last birthday) 58 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Willy Stark				14. MOTHER'S MAIDEN NAME Betty Minor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unk.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Decubital Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Huntington's Chorea (c) Known since 1943						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 55 , to June 19 56 , that I last saw the deceased alive on June 13 19 56 , and that death occurred at 1:40 a. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 6/14/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/56		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hildegard Heard Reissmann				ADDRESS Crownsville, Md.		24a. REC'D BY REGISTRAR DATE 6-20-56	
				24b. REGISTRAR'S SIGNATURE H M Lee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE DEPARTMENT OF HEALTH—BIRMINGHAM

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River, Beechwood Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Stewart</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24th</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/33</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Genivie Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. G. Stewart, (Mother)</u>		Address <u>24 Jones Avenue, Balt., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>929.8</u> IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped off a row boat.</u>	
20c. TIME OF INJURY Month, Day, Year <u>6/24/56</u> Hour <u>5:55 P.</u> o. m. <u> </u> m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>		20f. (City or town) <u>Beechwood Beach</u> (County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6/25/56 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Glen Burnie, Md.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem</u>	22d. LOCATION (City, town, or county) <u>Catonsville</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Henney</u>		ADDRESS <u>578 W. Biddle St</u>	
24a. REC'D BY REGISTRAR <u>June 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. D. Allen</u>	

1956 27 JUN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5875 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05793

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne rundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Russell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crystal Beach, P.O. Pasadena 2 hrs.</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magothy River</u>				d. STREET ADDRESS <u>Coolwood</u> 838-3			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Stinson</u> Last <u>Stinson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14th</u> Year <u>19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/41</u>		9. AGE (In years last birthday) <u>14</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland Virginia.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glen Davis Stinson</u>				14. MOTHER'S MAIDEN NAME <u>Florence Agnes Artrip</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Herbert E. Stinson, (Uncle) Baltimore 27 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Drowning</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowning</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6</u> p. m. <u>6/14/56</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Magothy River</u>		20f. (City or town) (County) (State) <u>Crystal Beach, A.A. Maryland.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>6/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Honaker, Virginia</u>				24a. REC'D BY REGISTRAR <u>6-18-56</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burnie, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>James J. DeAlba</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5896

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Lake Shore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blond Park AA Co MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Blond Park</u>				d. STREET ADDRESS <u>Pasadena MD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Amelia I Strecker</u>				4. DATE OF DEATH <u>June 13 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24 - 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Kohlhoff</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles Strecker</u>		Address <u>Blond Park AA Co MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260x</u> (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertension, mild</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1-hour</u> <u>6-years</u> <u>Not known</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus - 5 years duration</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>54</u> , to <u>June 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>56</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena MD</u>			
DATE SIGNED <u>6/13/56</u>							
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				ADDRESS <u>RFD 8 Box 442 Pasadena MD</u>			
DATE SIGNED <u>6/13/56</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elgin Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>AA Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A Fink</u>				ADDRESS <u>426 Cran Hygiene Blvd</u>		24a. REC'D BY REGISTRAR <u>L J Dealba</u>	
DATE <u>6-16-56</u>				24b. REGISTRAR'S SIGNATURE			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 Filed 1986-18-56 et

5897

CERTIFICATE OF DEATH

05795

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>407 Lincoln Ave.</u>		STREET ADDRESS (If rural give location) <u>1706 N. Calvert St.</u>					
3. NAME OF DECEASED (Type or Print) <u>Warren Octavius Towles</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6/10/56</u> <u>19</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>4/13/56</u> <u>4/13/73</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lancaster, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas P. Towles</u>				14. MOTHER'S MAIDEN NAME <u>Elberta Lealand</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mabel T. Kirkham (daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
446X IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>						<u>1 Month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/6/56</u> , 19 <u>56</u> , to <u>6/10/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/8/56</u> , 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Sorce</u>				DATE SIGNED <u>6/10/56</u>			
M.D. <u>Glen Burnie, M.D.</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>WHITE MARSH CH. CEM.</u>		LOCATION (City, town, or county) (State) <u>BROOKLINE, VA.</u>	
24. REC'D BY REGISTRAR <u>6-13-56</u>		REGISTRAR'S SIGNATURE <u>Louis J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Sorce</u>		ADDRESS <u>4001 Ritchie</u>	

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05796

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum PO (Rural)</u>				c. LENGTH OF STAY IN 1b <u>Few Seconds</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Expressway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Townsend</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1907</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Patterson, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry Townsend</u>				14. MOTHER'S MAIDEN NAME <u>Mary Guilfoil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Ruth Townsend - 212 Edgevale Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Macerated Skull & Complete Severance of Right Arm at the Shoulder</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Collision</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>6/5 1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway St. Rd. Linthicum PO, AA</u>		20f. (City or town) (County) (State) <u>Baltimore, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				DATE SIGNED <u>6/5/56</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Baeto 17 Md</u>				24a. REC'D BY REGISTRAR DATE <u>June 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>R W Caldwell</u>	

RECEIVED

BUREAU'S

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05797

5809 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort G. G. Meade</u>		<u>16 Years</u>		TOWN <u>Baltimore</u>		<u>3 VOI-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>5939 Hilltop Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>INFANT GIRL WALKER</u>				<u>June 17 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>June 17, 1956</u>	
9. AGE last birthday <u>Yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
						<u>3 40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel E. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Evva T. Bywater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Evva Walker, Mother, 5939 Hilltop Avenue, Balto, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>776X Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 40 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 June, 19 56</u> , to <u>17 June, 19 56</u> , that I last saw the deceased alive on <u>17 June, 19 56</u> , and that death occurred at <u>0415AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. Richard A. Gilbert</u>				ADDRESS (Street, city, town, state) <u>USA, Ft. G. G. Meade, Md.</u>		DATE SIGNED <u>17 Jun 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>19 Jun 56</u>		NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab</u>		LOCATION (City, town, or county) (State) <u>Fort G. G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt. MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS	
DATE <u>18 Jun 56</u>							

2050161XVO

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

52

ATTEST: I HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE FACTS AS REPORTED TO ME BY THE REGISTRAR OF DEATHS.

<p>NAME OF DECEASED</p> <p>AGE</p> <p>SEX</p> <p>RACE</p> <p>DATE OF BIRTH</p> <p>DATE OF DEATH</p> <p>PLACE OF BIRTH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>IMMEDIATE CAUSE</p> <p>INTERMEDIATE CAUSE</p> <p>UNDERLYING CAUSE</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS BROTHERS</p> <p>PREVIOUS SISTERS</p> <p>PREVIOUS AUNT</p> <p>PREVIOUS UNCLE</p> <p>PREVIOUS GRANDPARENTS</p> <p>PREVIOUS GRANDSIBLINGS</p> <p>PREVIOUS GRANDBROTHERS</p> <p>PREVIOUS GRANDSISTERS</p> <p>PREVIOUS GREAT AUNT</p> <p>PREVIOUS GREAT UNCLE</p> <p>PREVIOUS GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDSISTERS</p>	<p>REPORTED BY</p> <p>DATE OF REPORT</p> <p>PLACE OF REPORT</p> <p>REPORTED TO</p> <p>DATE OF INTERVIEW</p> <p>PLACE OF INTERVIEW</p> <p>INTERVIEWED BY</p> <p>DATE OF SIGNATURE</p> <p>PLACE OF SIGNATURE</p> <p>SIGNATURE OF REGISTRAR</p> <p>DATE OF DEATH</p> <p>PLACE OF DEATH</p> <p>CAUSE OF DEATH</p> <p>IMMEDIATE CAUSE</p> <p>INTERMEDIATE CAUSE</p> <p>UNDERLYING CAUSE</p> <p>PERIOD OF ILLNESS</p> <p>PREVIOUS ILLNESS</p> <p>PREVIOUS SURGERY</p> <p>PREVIOUS TRAUMA</p> <p>PREVIOUS DRUGS</p> <p>PREVIOUS ALCOHOL</p> <p>PREVIOUS TOBACCO</p> <p>PREVIOUS OTHER</p> <p>PREVIOUS OCCUPATION</p> <p>PREVIOUS HOBBIES</p> <p>PREVIOUS RELIGION</p> <p>PREVIOUS EDUCATION</p> <p>PREVIOUS MARRIAGE</p> <p>PREVIOUS CHILDREN</p> <p>PREVIOUS PARENTS</p> <p>PREVIOUS SIBLINGS</p> <p>PREVIOUS BROTHERS</p> <p>PREVIOUS SISTERS</p> <p>PREVIOUS AUNT</p> <p>PREVIOUS UNCLE</p> <p>PREVIOUS GRANDPARENTS</p> <p>PREVIOUS GRANDSIBLINGS</p> <p>PREVIOUS GRANDBROTHERS</p> <p>PREVIOUS GRANDSISTERS</p> <p>PREVIOUS GREAT AUNT</p> <p>PREVIOUS GREAT UNCLE</p> <p>PREVIOUS GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GREAT GRANDSISTERS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT AUNT</p> <p>PREVIOUS GREAT GREAT GREAT GREAT UNCLE</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDPARENTS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDSIBLINGS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDBROTHERS</p> <p>PREVIOUS GREAT GREAT GREAT GREAT GRANDSISTERS</p>
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BUREAU V. E.

JUN 21 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05798

Reg. Dist. No.

13

5810

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> d. STREET ADDRESS <u>Broadview Blvd.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Broadview Blvd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET PEARL WARFIELD</u>			4. DATE OF DEATH Month Day Year <u>June 26, 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1876</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>(unknown) Kelley</u>			14. MOTHER'S MAIDEN NAME <u>(unknown)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Paul R. Warfield Broadview Blvd. Linthicum</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Ling</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 28 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Caldwell Woodruff</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNAPOLIS STATE DEPARTMENT OF HEALTH - MINNAPOLIS, MINN.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
UN 28 1956
BUREAU V. 1

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05799

5811 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1309 William St.</u>				STREET ADDRESS (If rural give location) <u>1309 William St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry Wehner Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 24 1956</u> 19 <u>56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>12/12/80</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Presshand</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wehner</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-07-7657</u>		17. INFORMANT & ADDRESS <u>Harry Wehner Jr. (Son).</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>443X Hypertensive Cardio-Vascular Diseases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>over 3 months.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10th, 1956</u> , to <u>6/24/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/20/56</u> , 19 <u>56</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Kustave H. Baer</u>		M.D. <u>Glen Burnie, Md.</u>		DATE SIGNED <u>6/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>GA Co Md</u>	
24. REC'D BY REGISTRAR <u>June 26, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Frink</u>		ADDRESS <u>Glen Burnie Md</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 28 1956

RECEIVED

5812 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Millersville</u>		<u>3 Wks.</u>		TOWN <u>Baltimore</u>		<u>3 Yrs. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3507 Walbrook Ave.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle) <u>E.</u>		(Last) <u>Whaley</u>		(Month) (Day) (Year) <u>June 19, 1956.</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 27, 1868</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>---</u>		<u>Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Bernard Saidler</u>				<u>Elizabeth Warren</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Gladys V. Whaley, Pasadena 2, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>				<u>unknown</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>bilateral blindness</u>				<u>5 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10, 1956</u> to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city, town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>June 19, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-22-1956</u>		<u>Druid Ridge</u>		<u>Pikesville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>6-21-56</u>		<u>Rachmo M. Joyce</u>		<u>G. Howard Strong</u>		<u>3207 W. North Ave.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Date of Death

Place of Death

County of Death

Age at Death

Sex

Color

Married

Single

Widowed

Occupation

Cause of Death

Place of Birth

Age at Birth

Sex at Birth

Place of Death

Age at Death

Sex at Death

Place of Birth

Age at Birth

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Age at Death

Sex at Death

BUREAU V. 3

JUN 21 1956

RECEIVED

Howard Strong

RECEIVED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/SJS/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5754

CERTIFICATE OF DEATH

05801

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.d. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Williams</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>a.d. Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nesb</u>		14. MOTHER'S MAIDEN NAME <u>Anna Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, be- or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Will Williams - Millersville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331X</u> DUE TO <u>(Cerebral hemorrhage)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-26-56</u> , 19 <u>56</u> , to <u>6-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-5-56</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D. <u>62</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral</u> DATE SIGNED <u>6-7-56</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		<u>62 CATHEDRAL</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II - Annapolis, Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>8</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

MAY 1980 STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 31

11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5755

CERTIFICATE OF DEATH

058021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Staterbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Agnes General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Perris Wilson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Emma Wilson - Staterbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Hypertension</u> DUE TO (c) <u>Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/24/56</u> to <u>6/27/56</u> , that I last saw the deceased alive on <u>6/24/56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D.		ADDRESS (Street, city or town, state) <u>110-Clay St Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON</u>		DATE <u>110-CLAY ST ANNAPOLIS, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-30-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Staterbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>Wm. J. French</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

Cardinal Newman
 Catholic Cemetery
 Boston, Mass.

5 days

BUREAU V. 2

2/1/52

2/1/52

2/1/52

RECEIVED
 JAN 29 1952

110-6142
 110-6142

R. L. Richardson
 110-6142

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05803

CERTIFICATE OF DEATH

5756

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>AnneArundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>6-MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
TOWN <u>ANNAPOLIS</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home wood-Conalescant-home</u>				STREET ADDRESS (If rural give location) <u>1002 Nancy Road-Dak Ridge</u>			
3. NAME OF DECEASED (Type or Print) <u>Lila</u> (First) <u>Elizabeth</u> (Middle) <u>Woodbury</u> (Last)				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 4, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Levi Winnie</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or upk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr. Mark Woodbury 1002 Nancy Road Glen Burnie, Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL ARTERIOSCLEROSIS</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 5, 1955</u>, to <u>17 June 1956</u>, that I last saw the deceased alive on <u>17 June</u>, 19<u>56</u>, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward Beck</u>		M.D. <u>41 South St. Annapolis</u>		DATE SIGNED <u>6/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. V. Lingh</u>		ADDRESS <u>1111 Beech St. Baltimore, Md</u>	
DATE <u>6-21-56</u>							

BUREAU V. 2

JUN 21 1956

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

2758

PHOTOGRAPH

1. Name of deceased (Print name in full)
2. Date of birth (Month, day, year)
3. Sex
4. Race
5. Marital status (Married, Single, Widowed, Divorced)
6. Usual residence (Street, city, county, state)
7. Cause of death (Immediate, underlying, contributing)
8. Date of death (Month, day, year)
9. Place of death (Home, Hospital, etc.)
10. Signature of physician (Print name, M.D.)
11. Signature of registrar (Print name, M.D.)
12. Signature of informant (Print name, M.D.)
13. Date of registration (Month, day, year)
14. Registrar's office (City, county, state)
15. Registrar's name (Print name)
16. Registrar's title (Print title)
17. Registrar's address (Street, city, county, state)
18. Registrar's telephone (City, number)
19. Registrar's fax (City, number)
20. Registrar's e-mail (City, address)
21. Registrar's website (City, address)
22. Registrar's social media (City, address)
23. Registrar's other contact information (City, address)
24. Registrar's signature (Print name)
25. Registrar's title (Print title)
26. Registrar's address (Street, city, county, state)
27. Registrar's telephone (City, number)
28. Registrar's fax (City, number)
29. Registrar's e-mail (City, address)
30. Registrar's website (City, address)
31. Registrar's social media (City, address)
32. Registrar's other contact information (City, address)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05804

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marley Creek, off Johnson Peer.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u> d. STREET ADDRESS <u>Mountain Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Melvin Martin Wright</u> First Middle Last		4. DATE OF DEATH <u>June the 13th.</u> 19 <u>56</u> Month Day Year					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/39</u>	9. AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attending School</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>University Hosp. Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton James Wright</u>			14. MOTHER'S MAIDEN NAME <u>Esthel Stephney</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Milton James Wright (Father)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in Marley Creek, A.A. County.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1:50</u> <u>6/13/56</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Marley Creek</u> 20f. (City or town) <u>Glen Burnie, A.A. Maryland.</u> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>June 13th.</u> 19 <u>56.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>			
22d. LOCATION (City, town, or county) <u>Handsdown, A.A. Co., Md</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave.</u>					
24a. REC'D BY REGISTRAR <u>June 19 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUREAU V. 8

JUN 19 1956

RECEIVED